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ABSTRACT

This anthology contains 19 articles selected from the "Zero To Three Bulletin" from 1984 through the spring of 1992 and organized into five sections. The section on relationships in infant/toddler child care includes: "Infants in Day Care: Reflections on Experiences, Expectations, and Relationships," by J. H. Pawl; and "Choosing Child Care for Infants and Toddlers: Look First at the Caregiver," by S. Provence. Articles on applying principles to practice include: "Caring for Infants with Respect: The RIE Approach," by M. Gerber; "Mainstreamed, Mixed-Age Groups of Infants and Toddlers at the Bank Street Family Center," by N. Balaban; "The Center for Infants and Parents at Teachers College, Columbia University: A Setting for Study and Support," by A. Axtmann; and "Therapeutic Childcare at Merrywood School," by M. Siegel. The section on child care for infants and toddlers with special needs includes: "'The Sooner the Better Project': Involving Parents and Day Care Staff in the Identification and Treatment of Developmental Delays and Disturbances in Infants and Toddlers," by R. Clark and M. J. Oltmanns; "Models of Integration through Early Intervention/Child Care Collaborations," by M. B. Bruder, P. Deiner, and S. Sachs; and "Social Development and Integration: Facilitating the Prosocial Development of Typical and Exceptional Infants and Toddlers in Group Settings," by D. Wittmer and S. Petersen. Articles on supports for child care programs and providers include: (1) "Attending to the Emotional Well-Being of Children, Families, and Caregivers: Contributions of Infant Mental Health Specialists to Child Care," by K. Johnston and others; (2) "Whole Babies, Parents, and Pieces of Funds: Creating Comprehensive Programs for Infants and Toddlers," by P. D. Pizzo; (3) "The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddlers and Caregivers," by L. Torelli; (4) "Shared Reading in Daycare: Successes and Challenges," by G. J. Whitehurst and J. E. Fischel; and (5) "Managing Growth at Child Care Solutions," by R. A. Foote. The section on research in infant/toddler child care includes: "More Pride, Less Delinquency: Findings from the Ten-Year Follow-Up Study of the Syracuse University Family Development Research Program," by J. R. Lally and others; "Model Versus Modal Child Care for Children from Low-Income Families," by D. S. Wittmer; "Infant Day Care: A Cause for Concern?" by J. Belsky; "Responses to 'Infant Day Care: A Cause for Concern?'" (responses by eight authors); and "Infants, Families and Child Care: Toward a Research Agenda," a report from a meeting of infant day care researchers. (SLD)

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THE ZERO TO THREE CHILD CARE ANTHOLOGY

1984 – 1992

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THE ZERO TO THREE CHILD CARE ANTHOLOGY

1984 – 1992

Sally Provence, Jeree Pawl, and Emily Fenichel
Editors

ZERO TO THREE/National Center for Clinical Infant Programs
Arlington, Virginia
1992

National Center for Clinical Infant Programs

ZERO TO THREE/National Center for Clinical Infant Programs is the only national nonprofit organization dedicated solely to improving the chances for healthy physical, cognitive and social development of infants, toddlers and their families.

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- developing a broader understanding of how services for infants and toddlers and their families are best provided; and
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Note:

The text of each article in this anthology appears as it was originally published in *Zero to Three*. Some of the specific programs described here have grown, some have been discontinued, and all, inevitably, have changed. Readers who are interested in current infant/toddler child care research, practice, policy, and training are encouraged to subscribe to *Zero to Three* and to write or call **ZERO TO THREE**/National Center for Clinical Infant Programs, 2000 14th Street North, Suite 380, Arlington, Virginia 22201, tel. (703) 528-4300, TDD (703) 528-0419.

Cover photo: Subjects and Predicates

Introduction

The experiences of infants, toddlers, parents, and caregivers in child care have been an abiding concern of **ZERO TO THREE**/National Center for Clinical Infant Programs since its founding in 1977. Over the years, dozens of articles about various aspects of child care for infants and toddlers have appeared in our bulletin, *Zero to Three*—sometimes in issues devoted wholly to the topic of child care, sometimes in issues focused on other themes.

Our organizational (and editorial) attention to infant/toddler child care will continue. However, we thought it would be useful at this time to collect articles that have appeared in *Zero to Three* from 1984 through the spring of 1992, and make them easily available to child care professionals, parents, instructors, students, policymakers, and researchers who share our sense of the importance of early experience and our recognition that child care represents a significant chunk of early experience for many infants, toddlers and their families.

Somewhat arbitrarily (since a number of articles address more than one theme), we have grouped articles under five major headings:

- Relationships in infant/toddler child care;
- Applying principles to practice;
- Child care for infants *and* toddlers with special needs;
- Supports for child care programs and providers; and
- Research on infant/toddler child care.

We place **relationships** first in this collection because we believe, quite simply, that relationships are the major factor in determining the quality of child care. In the second section, on **applying principles to practice,** authors do just that—they tell us how their understanding of infants' and toddlers' development (and the developmental needs of parents) shape their child care programs' overall design and guide the most "ordinary" daily interactions among staff, children, and families. **Child care for infants and toddlers with special needs** is just beginning to receive the attention it deserves; authors of articles in this section emphasize the rewards of integration for all participants. The section on **supports for child care programs and providers** recognizes the variety of ways that individuals, communities, and public and private funders can strengthen the infant/toddler child care system—through financial support, contributions to the physical setting, and appropriate training and consultation.

The final section of this collection, on **research on infant/toddler child care,** requires some special explanation. The first two articles illustrate two types of child care research: 1) a longitudinal research and demonstration project that included infant/toddler child care as one element of

comprehensive support to families, and 2) an analysis of 1,000 hours of direct observation of two- and three-year-olds in child care settings. The third article, *Infant Day Care: A Cause for Concern?*, generated the largest number of letters to the editor on a single article in the 12-year history of *Zero to Three* (collected here as Chapter 18). The ongoing dialogue itself prompted the National Center for Clinical Infant Programs to hold an "infant day care summit" in the fall of 1987, which resulted in the consensus statement, *Infants, Families and Child Care: Toward a Research Agenda*, reprinted here as Chapter 19.

Realizing that experienced researchers can and do make different interpretations from data is important—not only for students learning to think critically but equally for parents, professionals and policymakers, who wish we could rely on "the research" to guide some of our most important public and private choices. We recommend that readers pay thoughtful attention to all voices in the infant day care dialogue, and that they themselves contribute to it. Meanwhile, the core of the consensus statement from the 1987 researchers' summit can remain our watchword:

When parents have choices about selection and utilization of supplementary care for their infants and toddlers and have access to stable child care arrangements featuring skilled, sensitive and motivated caregivers, there is every reason to believe that both children and families can thrive. Such choices do not exist for many families in America today, and inadequate care poses risks to the current well-being and future development of infants, toddlers and their families, on whose productivity the country depends.

The Editors of *Zero to Three*

Sally Provence, 1980 - 1985
Jeree Pawl, 1985 - 1992
Emily Fenichel, 1992 -

Relationships in infant/toddler child care

1

Infants in Day Care: Reflections on Experiences, Expectations and Relationships

by Jeree H. Pawl, Ph.D.

Day care, as an important experience for very young children, cannot be separated from our continued attempts to appreciate and understand relationships in general. Day care must be thought about and seen as occurring in a context of other relationships and as containing relationships.

When "relationship" is highlighted and articulated as the true issue for children, parents and caregivers, the understanding of what day care is shifts. It is only when *relationships* are recognized as the major issue that changes in the quality of care can happen that will make the day care of children more appropriate.

Understanding the experience of infants in day care does not, as it sometimes seems to, primarily involve an understanding of issues of separation. In fact, that focus as the major issue of concern may be far more central to the experience of the parent than it is to the experience of the child. There is a separation, of course, both as an event in reality and as a psychological process, but it all happens in a context—to very differently functioning children, with very different relationships with their parents and in very different day care circumstances. In addition, children in general have varying experiences with separation from major parental caregivers in situations other than day care.

We have expectations regarding the tolerances of infants and toddlers for separations that reflect parental needs and cultural styles. These expectations are not necessarily either natural or unnatural in some absolute sense. They are there. American babies for example, are known to nap alone and even sleep alone all night. Often too, mothers disappear when they lean over to tuck in the bedding and they're out of the line of sight of their infants who then may howl or may not howl. Mothers also go to the bathroom (though in my experience less frequently alone than they would like) and mothers may even go shopping while someone else cares for their sick child or just because they want to go shopping alone or with a friend and sometimes all day. In this culture—that is the way it is. On the other hand, surely no caveman or cavewoman ever sought a small cave next to theirs in which to place their infant at night. Sleeping with infants is probably evolutionally "natural" or at least has a very long history. More of the world does it than does not. It behooves one, then, to think very carefully about where we draw lines on what is clearly a continuum and to pay attention to why we are deciding that X is ok but Y is not.

Relationships are the major issue in day care.

The real task is to try to understand as much about infants' and toddlers' capacities and needs as we can and then to apply that to our understanding of children's experience and particularly to the individual child's experience, and that includes "day care."

First of all, of course, the phrase "day care" itself subsumes a wide range of caregiving

The assumption that care is all right because of consanguinity is about as sensible as assuming that biological parenthood automatically assures sensitive and thoughtful child rearing.

arrangements for children. Licensed center and licensed family day care are in the minority—representing a far lower percentage of out-of-home care than other arrangements.

More frequent arrangements include a neighbor who keeps several children, an unlicensed home where numbers of children are cared for, or a private arrangement with a friend or relative. It is interesting that in many of these latter arrangements concerns about separation and about the evils or virtues of day care barely arise. The same person who might deride center care may cheerfully drop her own child off with her mother each morning or have had three au pairs in her home in 14 months. Clearly, the *fact* of separation is not the issue for this woman; although arrangements which result in her not feeling guilty about her child's care may be her concern. So separation per se is only a part of a far larger and more important issue.

I have seen more than one child left in the care of a grandmother so incapacitated that the care was literally dangerous. I have seen mothers leave their infants with relatives whom they dislike and distrust and by whom they have felt *ill*-treated both currently and in the past. The virtues of this for the children were certainly limited, though quite real. They were with someone who had an ongoing meaning in their life, who may have conveyed her special investment in some way, and who would continue to be an important figure. Though even here, situations are very complex.

Recently, a young woman was referred to us after calling a Talk Line out of fear that she would injure her 19-month-old child. He was, she said, horribly aggressive and had been totally impossible from birth. In fact, what we learned was that since his birth, Jose had been left all day, 5 days a week with his parental grandmother while his mother worked, and that this grandmother had gone back to Nicaragua three months before. Jose's day care situation had shifted to a neighbor who had 6 children in her sole care and whom the mother herself described *as* rough and volatile.

It took time for this mother to appreciate the meaning of any of this. It took time to help this mother experience that her son's loss of his grandmother and subsequent inappropriate care arrangement were the major sources of Jose's very difficult behavior. She was able to remember that he had, in fact, not been "aggressive and impossible from birth." Their difficulty is resolving very nicely in the context of our program's weekly visits and a better day care situation.

In fact, this child had lost not only one major caregiver but had also effectively lost another—his mother. Because of her lack of understanding and her angry response to his expressions of grief, she was not available to him in any familiar reassuring way. His grief and despair burdened and angered her, and she rejected and punished him. When the mother was able to understand her son's experience, the problem for them both began to resolve, even though the loss of his grandmother's care remained a real loss to Jose. Jose is deeply attached to his mother, and with her restoration to him, he is functioning quite well. An appropriate day care experience is also salient to his good functioning. After the loss of his grandmother, his need for a day care environment which could be truly responsive to him was even more vital to his well-being.

Sometimes it may feel to parents that they have somehow abandoned their child when they have left their child in a day care center or professional family day care home, but that they have not abandoned that child when he is left with a grumpy and almost wholly incapacitated great aunt. The assumption that care is all right because of consanguinity is about as sensible as assuming that biological parenthood automatically assures sensitive and thoughtful childrearing. And this is illuminating. In either case the care may or may not be adequate. It may be only that the parent

will feel less guilty in one situation. This is certainly not unimportant; guiltlessness will have it own effect on the parent-child relationship. But what assuages the discomfort may be irrational.

What is it, in fact, that might make a parent feel more comfortable? Without a clear awareness of why it might really matter, the parent may feel comfortable in leaving a child when the child has a relationship with someone—a grandmother, a neighbor, or a friend.

There may be an unarticulated recognition of the importance of relationships even though in much of what any parent would read or hear, "separation" is often more discussed as an issue. In fact, in situations where a child is cared for by a neighbor, friend or relative, not only the child but the parent has relationship with that caregiver. The parent really *knows* who that person is and therefore has some faith, misplaced or not, in the appropriateness of the child's care. The same is often true of care provided in the child's home where the "sitter" becomes known to the parent as the two casually exchange daily information of all kinds.

This continuity for the parent, this reassurance, is often missing, though it need not be, in other kinds of care. In centers or other non-relational care, caregivers tend to be pressed for time, as is the parent, and sometimes out of discomfort the parent behaves as if there were a sharp division between two worlds and she simply leaves her child with an uneasy faith that he will be all right. She does not think, because it may seem irrelevant in these circumstances, of the "relationship" of her child to the adults or of her own to them; she only hopes that he is safe, fed and won't cry too much. Relationships between people are not necessarily conceptualized as the centrally important factor in day care, and the various continuities which are based on the adult relationship are often insufficiently appreciated.

As Sibylle Escalona assured us, infants can be relied upon to put together the available nutriments from their environments. The infant whose primary substitute caregiver is truly available for a responsive, respectful relationship or the infant who has several primary caregivers over the course of a long day, all of whom are appropriately available, has the opportunity to form some meaningful relationships. We would, of course, wish to limit the number of individuals to whom an infant must relate, and relate is the operant word. We want the experiences of the infant or toddler to be predictable and familiar, and the interaction to have within it those elements which allow the infant to experience her needs as recognized and responded to appropriately.

Such responsivity cannot be a consistent feature of a child's experience in a truly satisfying way if one person feeds, another diapers, another rocks and another sings songs. That degree of fragmentation creates relationships which are undoubtedly too shallow and too abbreviated. However, even if several people do all of these different things during certain serial time periods, a child is probably capable of establishing a sense of mutuality and effectiveness, and that is the major crucial and important factor. In these circumstances, infants will establish their own hierarchies of preferences, both between people in a general way and between people in specific ways. They certainly do this in family relationships. In the mood for hi-jinks? That's Uncle Bob's forte. Stomach ache? Mother handles that well. And Daddy is terrific at wandering around pointing at environmental adventures—like wiggly worms, airplanes, and dogs digging up the front lawn; besides, he has that specially silly sound he makes before he snuggles you in the tummy.

We allow and expect these predilections of infants and toddlers in the ordinary course of events, and they do not worry us at all. So too, the primary substitute caregiver will have her strengths, as will the parent. Overall, however, if there are no serious impediments to the parent child relationship a parent has far more than an edge. There

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Children may be soothed and comforted by others in their need for us to respond to all kinds of things—hunger, reassurance, play and attention—but will their need just to see us be totally assuaged? Probably not.

is no question that by and large the parent's investment in the child—his or her claiming of the child—is transmitted in unmistakable ways. No one else is so likely to make the child feel as good about herself, as special, as important or as valued. This unique sense of well-being and self-worth guarantees a powerful reciprocal response toward the person who generates that experience. And this person exists in the familiar surround of things and space and people that is where you come from and return to. There has never seemed any reason at all to worry that responsive parents will not matter most to a child.

So what are we worried about when small children are in day care? We think about their moment-to-moment experience. We do not want a child to feel lost or abandoned or to yearn painfully and endlessly for us and be helpless to fix things. This probably means, then, that separation experiences need to be titrated so as to become tolerable. It is not a good idea to be almost always available to a child and then suddenly leave him for 8 hours, 5 days a week, whether at 3 months or at two years. Over time, and in doses, the child must be given the opportunity to establish a relationship with the person with whom he is to be left.

And here we get to the issue of individual differences, as well as previous experiences. Some children find relative strangers quite upsetting, especially when they abruptly assume roles other than that of stranger. As we know, certain children will approach after awhile, and others will take a very long time. Some children can tolerate a quiet, non-intrusive presence whom they are free to engage or not, but they will howl with anguish if someone decides to approach them. But the parameters of the category "stranger" are very different for different children. Such differences are not in any simple way connected to a child's age. Some two-year-olds are as wary as some 9-month-olds. And some 9-month-olds are as sanguine as an experienced, outgoing three-year-old. Certain two-year-olds have almost zero tolerance for the absence of their mothers, while certain 9-month-olds adjust very rapidly. These varying tolerances reflect the temperament of the child, the quality of primary relationships, the child's experience with separation and the meaning of separation; even then this is all a complex transactional phenomenon with each of these things affecting the other.

One of the issues around separation is the issue of whether or not infants "remember" their parents—or what they experience in regard to them while separated. We know from Leon Yarrow's very early work that infants recognize a change in caregivers within at least weeks. We also know that infants and toddlers remember their parents when they are separated from them. If a five month-old can remember and demonstrate to us that she felt negatively or positively about one of two puppets which she encountered for 10 minutes one week before, then we are not likely to be forgotten. We don't need to wrestle with the differences between recognitive and evocative memory. The recognition of a familiar person and ability to call the person to mind in her absence are actually on a continuum; both are dependent on the child's experiencing certain cues associated with the person. In any situation, there will be sufficient internal and external cues to evoke memories of us in our absence. The cuing is subtle but very evocative. It is questionable, however, whether and when there is enough organized sense of our constancy and eventual reappearance to reassure and quiet the child's occasional yearning for us. Children may be soothed and comforted by others in their need for us to respond to all kinds of things—hunger, reassurance, play and attention—but will their need just to see us be totally assuaged? Probably not. So it matters even more that the care available at the moment does not leave the child feeling abandoned. (This is equally true even when a child is old enough to know that we will come at 4 o'clock.)

It's clear that affective memories as well as cognitive memories are encoded. The affective memories are encoded long before language. It is not clear *how*, but the evidence is overwhelming that they are. The internal models of relationships—what they promise and how they work—are gradually organized around specific, discriminated people—mothers and fathers and siblings and aunts and caregivers. Which aspects of these relationship experiences will be triggered by what later encounters is undoubtedly very complex. But we are certainly safest in trying to ensure a basic optimistic core to all of these early relationships where we can do so. Most vital, it seems to me, is that the infant or toddler is cared for in ways that promote his feeling effective, respected and understood much of the time. The sense of having needs met—the sense that relationships hold promise—will hinge not only on parental input into the child's experience of safety and trust; it will develop as well within relationships with others. If this occurs both with parents and with caregivers, then we have far less about which we must be concerned.

In addition to concerns about the child's experience in the moment, and mastery of separation, many of us have other concerns. What effect will early experiences in day care have on the quality of relationships which the child will be capable of in the future? Will the child have affective, unverbalized memories of abandonment and helplessness, and have poor trust in relationships? Are children monotropic—needing one kind of nurturance involving a single constant caregiver—and will they be damaged if this cannot be totally accommodated? We wonder whether, without this, a child will be capable of deep, abiding relationships characterized by intimacy.

In fact, these long-term issues can best be addressed by understanding and addressing short term issues. Where care is taken to assure safe, tolerable and rewarding relationship experiences in the present, we are doing the best we can to protect relationships in the future. To be able to assess the effects of day care on a particular child, then, a parent must acknowledge—really know—that she or he is leaving the child with a particular person or set of people; the parent will have to notice what the child's relationship with that caregiver is likely to be. I am sure all of us know how unbearable that is for many parents who have no good choices; if they looked and understood, they would find the reality intolerable.

Perhaps it is now time to ask if we, as a society, indeed wish our children to be capable of deep, abiding intimate relationships. I believe our answer would be a resounding "yes," but we might wonder if intimacy is in fact a valued quality in the majority of personal relationships these days. If intimacy is *not* part of a person's life, does its absence represent "freedom"? Are we as a society experiencing a re-evaluation of human relationships? How do we approach the transmission of cultural values in the midst of massive cultural change? It is difficult to think about, for it, too, is a transactional, almost circular phenomenon. Our habitual linear, unidirectional thinking fails us when we try to decide if our society is *creating* a problem with intimacy and separation or whether individual problems with intimacy and separation are creating a societal tolerance, if not a need, for major cultural shifts.

We can expect that parents who are forced to rely on day care for their infants or whose internal dynamics more comfortably fit with shared care will have led the way, while others strain and possibly break under the demand to place their children in substitute care. We can argue that the demand to place infants in day care will be met increasingly easily by the children of the children whom we are creating, as they will have no difficulty tolerating separation and attenuated intimacy. Or we might argue that with awareness and care we can create children who will balance the demands for separation with sufficiently healthy relationships to adapt without great personal cost both to

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what society now demands and what it yet still treasures.

We must recognize that in addition to pressures on parents of infants to remain in the work force, there are other cultural demands for mobility, geographical distance between nuclear and extended family members, and lengthy separations of infants and toddlers from their parents. It may be a three-year separation for little George, between the ages of 2-5; he is with Aunt Franny in Miami because his single mother in San Francisco can cope with her 7-year-old and her baby but not with him. Life for Jimmy consists of four days each week with mother and three with dad, now that he's two; his parents were separated before his birth. There are desperate immigrants who leave their children behind for years and then reclaim them. This family of five has moved three times in three years in pursuit of work promotions. Clearly these phenomena are both causes and effects. Some people seem to adapt with apparent ease to experiences which others might feel as alienation from close human ties. I think we must come to grips with the basic questions we are really asking and be hard-headed in our responses.

In a world filled with massive separations and losses, the issue of separation in day care is of minimalist concern. Yet if we can think well about this issue, we may find paths to addressing larger social concerns.

We could probably all agree that in our society one must be dependent, independent and interdependent to get the best of what may be gotten. We ought not feel that we can simply take or leave particular people, but we must feel that we can function for greater or lesser periods of time both with them and without them—enjoying the reality of all of those states. We can only do this if relationships are inside of us in good and nurturing ways. It is that positive internalization of mutually respectful and contingent relationships that makes flexibility possible. I have written this essay alone, but I could really master doing so because I am alone in the presence of someone. My mother, my father and other important relationships are embedded in my sense of myself in relation to a world of mutually interacting people whom I basically trust and with whom I feel secure.

For infants in day care, their world of mutually interacting people includes their day care providers. These caregivers make their own important contributions to what infants and toddlers come to expect of relationships and how they experience themselves. Only if that care is responsive, understanding, loving and contingent will a child's sense of his central importance, competence, effectiveness, and trust and safety be maintained.

In effect, as parents we can allow our child in day care to miss us, but she should not miss herself. Her sense of herself, and of herself in relation to others should not be damaged. That is the major loss in being separated from a good and adequate parent. Separation itself may be painful in many ways, but it pales in comparison with the child's loss of an effective, competent, well-loved self or a socially competent self who can relate and be related to. There must be relating partners who much of the time respond to a child as he is and in terms of his needs. There must be a sensitive, caregiving relationship, not mechanical caretaking.

The child in day care internalizes an important relationship, one that mixes and matches, is concordant with or nonconcordant with relationships with mother, father, siblings, and others. The degree to which these interactions share basic dimensions of respect, responsivity and mutuality is the issue. The 15 minutes shared with Uncle Al cannot compete in the moment, and is a different category of experience from, 8 hours, 5 days a week with Martha, even though Uncle Al may be around for the next 40 years. It is true that Uncle Al will be a part of one's ongoing life, but the Martha or Ann or Bess who cares for an infant or toddler over long periods of time and then disappears will be tucked away inside, shaping the child's expectations and coloring

what he imagines relationships can give him and what he can give them. Those expectations should be as hopeful and as promising as we can devise.

In closing, perhaps a quotation from a short story of Tillie Olsen's will convey what the essence is of what I am trying to say about parents, infants, and day care.

"She was a beautiful baby. She blew shining bubbles of sound. She loved motion, loved light, loved color and music and textures. She would lie on the floor in her blue coveralls patting the surface so hard in ecstasy her hands and feet would blur. She was a miracle to me, but when she was eight months old I had to leave her daytimes with the woman downstairs to whom she was no miracle at all .... Then she was two. Old enough for nursery school they said, and I did not know then what I know now—the fatigue of the long day, and the lacerations of group life in the kinds of nurseries that are only parking places for children."

Tillie Olsen describes what will *not* do. While we must know that not all babies are miracles to their parents, while we must know that no baby is perceived as a miracle all the time by parents, we must also steadfastly insist that each child in day care deserves the highest probability of being perceived as unique, of being appropriately and respectfully interacted with and of having predictable, trusting, mutually determined relationships. By the same token, each parent, and each caregiver, deserves respect, understanding, and support for his or her unique investment in the child. If we can also find ways to help ensure mutually respectful, trusting, and ongoing relationships *between* parents and caregivers then we will have the best kind of shared care for the child.

Day care must not be a "parking place for children" but a viable, rich place for safely learning more about the very complicated but very worthwhile things in the remarkable world of human relationships.

2

Choosing Child Care for Infants and Toddlers: Look First at the Caregiver

by Sally Provence, M.D.

Young children need to know and trust the adults who take care of them. Parents need to feel confident that their children are well cared for. Central to good child care for infants and toddlers are human relationships. Quality of the relationships available, along with a good physical environment and enough staff to give individualized care to infants in small groups, should be the primary basis for choosing a child care setting.

The increasing numbers of parents seeking supplementary child care for their infants and toddlers should be aware that for several reasons very young children need care planned specifically for them, not a scaled-down version of a program designed for older children. *First*, the rapid physical growth and developmental changes of infancy require a responsive, flexible caring environment. *Second*, the "routines" of infant care—feeding, bathing, diapering and comforting—are communications of utmost importance to the baby's cognitive, emotional, social and physical development, and should be performed with sensitivity to individual rhythms and needs of each infant. *Perhaps most important*, the formation of loving attachments in the earliest years of life creates an emotional "root system" for future growth and development.

Every child needs a solid relationship with one or two people in the family, and the infant or toddler in daycare needs a main caregiver (and limited involvement with other staff) so that continuity of affectionate care will be assured.

Thinking carefully about skills of the person who will actually be caring for an infant or toddler—whether in the child's home, in a family daycare home or in a group setting—may be the parent's most effective way of choosing child care that will support development.

As they observe a family home or group daycare setting or interview a potential caregiver, parents should recall that because children grow and change so rapidly in the first years of life, caregivers must be particularly flexible in their actions and able to adjust promptly to changing needs. What a caregiver does with a 5-month-old should be quite different from her actions with a 10-month-old, and different still from the blend of firmness, encouragement and warmth she will need to help a toddler develop.

The following description of a competent caregiver for infants and toddlers is drawn from evaluation criteria for the Child Development Associate Credential for infant/toddler caregivers currently being field-tested prior to nationwide application.

The competent caregiver for infants and toddlers:

- is patient and warm toward infants and toddlers.
- enjoys infants and toddlers and derives satisfaction from the ability to provide good care.

- is able to form affectionate attachments with children.
- knows how to provide good physical care; knows how to evaluate the surroundings for safety and comfort and how to recognize illness and unusual behavior.
- has sufficient health, energy and resourcefulness to enjoy and guide the abundant energy of infants and toddlers.
- recognizes feelings and responds appropriately; can help the child handle fear, sadness and anger as well as experience love, joy and satisfaction; and can adjust to rapid changes in feelings, behavior, and physical state.
- knows about the development of infants and toddlers in general and how needs and characteristics change during the first three years.
- appreciates infants and toddlers as individuals and takes cues about appropriate actions from the child's behavior.
- understands the importance and variety of learning needs and provides appropriate activities and materials to stimulate infant/toddler curiosity.
- engages the child, from the earliest infancy onward, in friendly verbal and nonverbal communication.
- is aware of the importance of limiting undesirable behavior but is not punitive or given to outbursts of anger toward the child.
- is acquainted with and appreciates the child's own culture, customs and language.
- respects the parents of the child in care and strives to support the parent-child relationship.

What does good infant/toddler child care look like?

Whatever may be spelled out in or left out of state licensing standards, described in brochures, or observed by parents on pre-enrollment visits, it is the day-to-day experience of infants and toddlers in a daycare setting that counts.

The following two vignettes, observed at the Children's House in New Haven, Connecticut, provide glimpses of caregivers in a program designed to support the development of infants and toddlers.

Leslie at 4 months: Looking, moving and grasping

From the time they were admitted to daycare, the young infants at Children's House were provided with variety in their visual environment through the use of mobiles, pictures, and changes of position. Playtime was sometimes in a crib, sometimes in someone's arms or in a supportive chair, sometimes on a rug or mat on the floor, sometimes out of doors on a blanket.

By 4 months Leslie was described as an exceptionally strong, vigorous, active baby. She bounced up and down while sitting or while being supported in a standing position on an adult's lap. She could reach for, grasp, and wave objects, and move her head and body to view things that interested her.

Several playthings were placed near Leslie wherever she was: in her crib, sitting in the infant's seat, or lying on her belly on the floor. She was offered brightly colored rattles, soft squeeze toys that made a squeaking sound, hard rubber teething rings, and fluffy, stuffed, cloth toys. These provided an assortment of shapes, colors, textures, and densities, which afforded Leslie a variety of stimuli and challenges from which she could learn. By changing the toys from time to time, her caregiver introduced variety and contrast.

Terry at 10 months: Investigating and experimenting

The following episode gives a picture of how much concentration a 10-month-old can show. It also reminds us that all "educational toys" need not be purchased—when adults are perceptive and supportive, children can learn from almost anything in the environment.

Terry was playing with an aluminum margarine cup and a flat stick that looked like a popsicle stick. He hit the cup with the stick several times, causing it to flip over. He then used the stick to scoot the upside-down cup along the floor. For ten minutes

he continued with great concentration, alternately flipping and pushing the cup and observing what happened. Later, while in the kitchen with KM, who was preparing food, he discovered the dishwasher and found he could roll the lower rack in and out. He kept pushing it in and pulling it out, smiling with pleasure as he listened to the changing clatter of the dishes. He then poked about in the soap well for several minutes. All of this was done in an engrossed, exploratory manner. KM spoke to him occasionally, commenting upon what he was doing but allowing him to carry through his project in his own way.

The adults made Terry's play possible by providing the margarine cup and stick and by allowing him the freedom to pursue his own interest. They supported him by being nearby but did not take an active part in his play at that time. It would have interfered with Terry's self-initiated investigations if someone had swooped down on him while he was so busily and happily engaged with the cup and stick to take him away for a bath, or to introduce, or substitute a "proper" toy. Later, taking Terry into the kitchen and permitting him the freedom, with supervision, to explore the dishwasher, KM provided a wider variety of experiences that would have been available to him in the playroom. He was learning through following his interest of the moment, supported by an adult. At other times of the day he was involved in adult-initiated activities.

Applying principles to practice

3

Caring for Infants with Respect: The RIE Approach

by Magda Gerber, M.A.

Walking into a RIE workshop for new mothers and infants, you might encounter the following scene:

Five mothers sit quietly observing their infants in the adjacent play area. One baby has discovered a multi-colored ball, filled with just enough air for his palmar grasping skill. Another infant sits quietly, looking pensively at her reflection in the dome of an upside-down aluminum mixing bowl. Two adults sit attentively among the infants. One 8-month-old baby approaches another with outstretched fingers, heading toward an open eye. One of the adults moves closer.

David reaches for Susan's eyes. Just in time the educarer touches his hand and gently strokes both babies, softly saying, "David, you want to touch Susan's eyes, but eyes are delicate. We touch faces very gently."

Resources for Infant Educarers (RIE), founded in 1978, is a non-profit membership organization concerned with improving the care and education of infants. RIE offers parent-infant guidance classes, certification training for professionals, public workshops and conferences, and consultations to infant group care centers. These services all present the RIE approach, a humanistic-therapeutic way of working with infants based on my psychoanalytic training and work as a child therapist. To emphasize how educating and caring for an infant should be inseparable, I coined the words "educarer" and "educaring" to describe RIE's surprisingly simple and commonsensical philosophy, which differs so markedly from current trends.

We should educate while we care and care while we educate. Most people think of stimulating, exercising and teaching infants as important, glamorous activities. They think of diapering, feeding and bathing as unpleasant or mundane daily chores. RIE, however, suggests that caring activities are *the* optimal times for interaction, cooperation, intimacy and mutual enjoyment, providing social learning experiences which encourage full participation of the infant and her educarer. "Refueled" by such caring experiences, infants are ready to explore their environment with only minimal intervention by adults. A predictable balance of togetherness and separateness is achieved which benefits both infants and adults.

The RIE philosophy: Observing the infant explorer

Giving the infant time, attention, trust and respect is the foundation of the RIE philosophy. Our goal is an authentic child—one who feels secure, autonomous, and competent. Our method, guided by respect for the infant's competence, is observation. RIE trusts the infant to be an initiator, an explorer and a self-learner. Because of this basic trust, we provide the infant with the minimal help she needs to overcome an impasse and allow the child to enjoy mastery of her own actions.

Educarers are sensitive observers—available when direct help is needed, but not intrusive when the infant can solve her own problems. We provide an environment for the child that is physically safe, cognitively challenging and emotionally nurturing. There the child may freely explore and manipulate, fully involved in learning projects of her own design.

We allow infants to do what they are ready and willing to do. We reinforce their self-initiated activities by paying full attention, while being quietly available, and by appreciating and enjoying what the infants actually do. Occasional reflections such as "You touched the ball, and it rolled away" reassure the child of our full attention. Saying "It's hard to separate the two cups" shows our empathy. A joyful smile when the infant solves a problem conveys our pleasure in his success. As we value inner directedness in a child, we prefer gentle validations to instructions, to criticism, and even to praise.

Contrast with other approaches

This approach contrasts strongly with those used in most infant programs. In programs I have visited, children are taught, encouraged and expected to do what they are basically not ready to do. Too many infants are being propped up when they cannot yet maintain a well-balanced sitting position, or are given a toy which they have neither freely chosen nor can freely manipulate. Similarly, putting infants into devices such as infant seats, walkers, swings, or bouncers restricts them from moving freely. Such devices introduce positions or movements for which the infant is not yet ready.

RIE believes that a child who has always been allowed to move freely develops not only an agile body, but also good judgment about what he can and cannot do. Developing good body image, spatial relations and a sense of balance not only helps the child learn how to move, but also how to fall and how to recover. Children raised this way hardly ever have any serious accidents.*

In contrast to the "experts," reinforced by the media, who urge parents to raise "superbabies," RIE emphasizes the benefits of infants' spending peaceful, uninterrupted time following their biological rhythms of falling asleep when sleepy and eating when hungry, rather than having to adjust too soon to external schedules and unrealistic expectations. We try to reassure parents that infants do do what they can do—and should not be expected to do what they are not ready for.

Parents in the RIE program learn how infant and family rhythms develop into predictable routines and how "separate time" and "together time" can be enjoyed. When infants are allowed uninterrupted play time between caregiving activities, parents can have their own time as well. Children who have learned to rely on being stimulated, manipulated and entertained by adults may lose their capacities to be absorbed in independent, exploratory activities. Their parents easily becomes slaves of the nagging child/tired parent syndrome they themselves unwittingly helped to create.

As parents and professional students learn to observe, they realize that being "busy" can keep one from intimacy, from really giving oneself, from paying full attention. They begin to see how many parents work too hard and try too hard—carrying babies around through sleepless nights, buying expensive toys, learning cribs and teaching kits; teaching, programming, and following prescribed curricula and forgetting what is most important—that all those everyday, routine experiences, like feeding, dressing, bathing and diapering have the greatest effect on their baby. We reinind parents of the cumulative effect diapering alone—which occurs some 7,000 times in an infant's life—can have on their child.

*At the National Methodological Institute for Residential Nurseries, better known as Lozzy, in Budapest, Hungary, more than 2,000 infants have been raised with the philosophy described here. In 37 years of raising infants from zero to three, they have had no serious accidents.

RIE principles in group care

We believe that their own home is the natural habitat for the infant. Many infants, however, spend many hours, and sometimes their whole waking day, in group care. While RIE principles are applicable wherever infants are raised, their use is particularly important in the context of group infant care.

To be very special to the people who care for him or her is the right of each infant. This being special and being important is usually experienced within the child's own family. It gives the child a sense of self and a sense of belonging. Group care must work especially hard to impart this sense, since even with understanding staff, the child becomes one of many. It is therefore all the more important that during caregiving activities a special relationship develops between the infant and the carer, who would ideally be the same person over time. The idiosyncracies, the unique style and tempo of each infant should be acknowledged and respected. The infant also learns to adapt to the characteristics of his special caregiver. This kind of relationship helps the child develop a sense of his own identity.

Group care can be beneficial when the environment and schedule are:

- set up to serve the child's needs
- predictable and consistent and
- allow the child to explore and interact with other infants.

These conditions can be met most easily in a small group of 4-6 babies or toddlers. Environment and scheduling combined with special relationships during caring may compensate for the loss of time spent at home.

Professional certification training

In RIE professional certification training classes, educarers develop observational skills, become sensitive to each infant's needs and personal characteristics, and learn how to convey a feeling of specialness to an infant even though he must share carers.

The following sample dialogue illustrates the interaction and learning opportunities in an everyday encounter.

CARER	INFANT	INFANT LEARNS:
Greets child "You seem to be having a good time with your rubber giraffe		To anticipate
Tells and shows what she is going to do but I want to pick you up and diaper you."	Pays attention	To pay attention
Waits for infant's reaction "You're not quite ready so I'll wait a little. (One or two minutes later)	Responds to the initiations of carer (positively or negatively)	Both learn To be responsive to other's expectations
Asks for cooperation or follows child's lead "First we have to remove your overalls. You pull out your foot."	Cooperates and participates	The joy of pleasing and actively participating
Encourages mastery "You helped with this (touches foot) now pull out the other foot."	Achieves mastery Becomes playful, teasing, doing the opposite of what is asked	The joy of mastery Autonomy Security challenge
Enters the game but eventually gets back to task (business). "This (smiling) doesn't look like a foot. but more like a hand to me."	Enjoys the process; laughs	The joy of doing a task together
Enjoys the Process		

The three phases of RIE training include comparison of infant development theories, observation of local infant environments, and demonstration of the RIE approach in our parent-infant classes. Our own unique audio-visual library, including films of infants raised at the Loczy Institute,

Hungary, and films, slide shows and videotapes made of our own programs, provide additional resources for our RIE interns.

Our students come from diverse disciplines, geographic areas and work settings. They are nurses, physical therapists, psychologists, early childhood educators, social workers, child care workers, family day care providers and administrators. They work with normal, at-risk and handicapped infants and their families.

RIE programs offer professional training, parent-infant guidance classes and community education. Our work is both therapeutic and preventive. We believe that infancy is a crucial time to develop basic patterns of trusting, relating and learning. RIE supports wellness from the very beginning of life.

4

Mainstreamed, Mixed-age Groups of Infants and Toddlers at the Bank Street Family Center

by Nancy Balaban, Ed.D.

The setting is the Bank Street Family Center in New York City. Three children are seated at a small table, each with a dish of paint, paper, and brush. Charlie, aged 2.11, carefully paints his left hand, one finger at a time. He presses the now red hand firmly onto the paper. "Look!" he exclaims to the caregiver, eyeing the hand print. "I did it!" Gabe, 2.3, makes sweeping strokes of red on his paper, then swirls the wooden handle tip through the painted marks. "You used both ends of the brush on your paper," the caregiver comments. Melanie, 11 months, dips her brush in the paint and examines the trail it leaves on her paper. She feels the paint with her hand, puts the brush into her mouth, then makes more marks on the paper. The three children are absorbed in painting for nearly 20 minutes.

Mixed-age groups of children six months to three years old interact with one another in many different ways every day in the Bank Street Family Center, a full-day, mainstreamed child care facility at Bank Street College of Education. The Center's intent is to replicate the natural age span that occurs among children in family groups. Each of the Center's two infant/toddler groups consists of at most 10 children, two of whom are under a year old, and one or two of whom have a specific disability. The limit of two babies younger than one year per group reflects the great amount of attention young babies need. There are three caregivers in each group at all times. Families can choose to enroll their children for time slots ranging from three half-days to five full days per week. It is possible for a child and family to continue with the same caregiver for two years and to remain in the Family Center itself for three years.

Although very little has been written about mixed-age grouping of young children, particularly infants and toddlers, anthropologist Melvin Konner reminds us that grouping children in same-age groups is a fairly recent phenomenon, designed by adults rather than chosen by children. He notes that:

> *[In] human hunter-gatherers, in all apes, in almost all monkeys that have been studied, the nearly ubiquitous play group is a temporary, multiage group of juveniles. The advantages of the multiage composition of play groups for transmitting nongenetic aspects of behavior in higher animals, for protecting younger children, and for facilitating smooth integration of infants into a wider social world, are clear.* (1975, p. 122)

When children form groups spontaneously, they are not rigid about the age of their playmates. Ellis, Rogoff and Cromer (cited in Katz, 1990) observed that children in spontaneous groups chose to play with same-age peers six percent of the time, but chose playmates who differed by at least a year in age from themselves 55 percent of the time.

Konner sees the relations of children of different ages as constituting a distinct

"affectional system" (p. 123). Such a system can be readily observed in the Family Center: children bring toys or bottles to another, embrace another, play alongside or with another, grab playthings, push or hit another, or take another's food. Many of the children's feelings and experiences with each other in the center mirror those that exist between siblings or among children's friends in the wider community. Indeed one of the advantages of a mixed-age child care setting is the opportunity it affords children who have older or younger siblings to express some of their rivalrous feelings in a non-judgmental environment. In addition, the mixed-age setting gives single children the experience of a child-populated milieu.

In the following anecdote, a toddler expresses her feelings about a sibling figure within the benign setting of the Family Center.

Sam, 8 months, is on Joyce's lap, engaged in a "drop the clothespin into the can" game. When Joyce drops the clothespins, Sam retrieves, then chews on them. Twenty-three-month-old Zoe watches from across the room. Suddenly, Zoe swoops in close to Sam, hugs him roughly around the neck, grabs the clothespin from his mouth, and runs off into the other room. Sam screams. Joyce comforts him. In a few minutes, Zoe returns. She hands the clothespin to Sam. "First you took it away, and now you're giving it back," Joyce observes to Zoe.

Sam was startled, but not hurt. He learned that although an older child can be a threat, he can count on the adult to protect him. And Zoe, who responded to an impulse, had time to feel some twinge of guilt as she raced around, clutching Sam's clothespin. On returning the object, Zoe learned that a prosocial act is worthwhile—it has its own rewards.

Opportunities for social development among children

The mixed-age group provides many opportunities for children to develop social, caring and nurturing capacities. Particularly before they begin to talk fluently, toddlers learn a great deal by imitating the behavior of children who are both older and younger than themselves. During the 16 to 32 month period, imitation can be seen as a "developmentally mature act" (Eckerman, Davis & Didow, 1989, p. 450) that will help toddlers become full partners in play with other children.

However, toddler interactions in the mixed-age group are not limited to imitation. A recent study of children 18 months and 24 months (Brownell, 1990) found that pairing a younger and an older child led to more interaction and more turn taking than occurred with pairs of children the same age. One- and two-year-olds were seen actively *adjusting* their behavior to others, not merely imitating. The older children in the mixed dyads made more complex and frequent social overtures to their younger partners than to their same-age peers. The 18-month-olds were more interactive with two-year-olds than with their exact contemporaries. In a study of larger groups of children, Goldman (1981) found that a mix of ages facilitated the social participation of both older and younger preschool children.

We might speculate that children in a mixed-age setting begin to learn what to expect from older and younger playmates and how to behave toward them. Children in primary school mixed-age classes look to older children in the group for leadership and help, and are drawn to give "sympathy" to younger children (French, 1984). In the Family Center, we see three-year-olds organizing the play in which two-year-olds take part. We see two-year-olds often comforting and gently patting one-year olds and infants. Perhaps these behaviors are the precursors of altruism.

Relationships in the mixed-age group may also represent the beginnings of true friendship (Hartup, 1975). We frequently see infants as young as seven or eight months expressing preferences among children in the group. They become excited when a special friend arrives for the day, may offer a tangible "gift" to another child, or become agitated when less favorite child makes an overture.

Opportunities for social development through continuity of care

A child enrolled in a mixed-age group at the Family Center is virtually assured of remaining with the same caregivers and some of the same children for at least two years. Because stability of caregivers and of the child care setting are associated with the development of social competence (Howes & Stewart, 1987), this arrangement offers a distinct advantage to children and families.

Howes (1988) found that toddlers who spent a year or more together in a group were more socially competent and had less difficulty with each other than children who had been in the group less than a year. Further, children who moved with their friends to a new group had less difficulty adjusting to the new group than children who moved without friends.

Based on these empirical findings as well as our conceptual understanding of the importance of early relationships, the Family Center makes every attempt to provide continuity of care. Sam, who entered as a six-month-old, will be cared for by the same person next fall when he is 18 months old. It is even possible that he will be with the same caregiver the following year, when he is 30 months old. Changes occur in the child membership of the group only when the older children go to the preschool group and younger children enter. Children are *not* moved when they reach a certain age or attain a specific skill, like walking.

Opportunities for learning skills

In the family, children who are six months to three years old reach, mouth, grasp, babble, feed themselves, crawl, walk, talk, and make-believe. In the Family Center, children learn many different skills from one another. In the following anecdote, children learn how to enjoy singing together and observe the skill involved in playing a musical "instrument."

Nine children, aged 18 to 38 months, are sitting comfortably in a circle with three caregivers. Bess, the caregiver, has given each child a pair of percussion sticks and starts to sing a familiar song while tapping her sticks together. All the children are very absorbed in the songs, even though only the older ones sing and play consistently. The three year olds, "play" their sticks and sing most of the words. Twenty-three-month-old Helen sits, watching the three year olds. After the third song, she begins to tap her sticks together once or twice. As the singing ends, Rosie, 20 months, sings "Ba, ba, ba!" strikes her sticks, and smiles broadly.

The mixed-age group fosters skill in pretend play. While Piaget postulated that children begin "role enactment" at age three, Dunn and Dale (1964) found that two-year-olds who play with mother and older siblings begin "to understand, cooperate in, and contribute to joint pretend play considerably earlier than supposed" (p. 134). While not yet able to "plan" the play, two-year-olds can perform the roles assigned them.

Indeed, Vygotsky's concept of the "zone of proximal development" (1978) may provide a more relevant model for understanding mixed-age groups than Piaget's observations. Vygotsky defines the *zone of proximal development* as

the distance between the actual developmental level, as determined by independent problem solving, and the level of potential *development, as determined through problem solving under adult guidance or in* collaboration with more capable peers.... *what is in the zone of proximal development today will be the actual developmental level tomorrow—that is, what a child can do with assistance today she will be able to do by herself tomorrow.* (pp. 86-87, emphasis added)

Playing with both older and younger children provides intellectual and social challenges that guide the less mature, younger child to internalize new understandings and skills. Seasoned child care providers (Hignett and Rossiter, n.d.) know the value of two-year-olds watching three- and four-year-olds using the toilet. The father of a 10-month-old, watching his baby interact with older children in the Family Center, exclaims, "He's so sophisticated!" It is important to remember, of course, that just as in a real family, children in a mixed-age child care group need individualized

attention. In order to meet the needs of the wide age range in Family Center groups and to minimize the press of the group during the long day, the caregivers frequently divide the children into smaller groups. In the morning, for example, two children and a caregiver may go out to buy fruit for snack at the local market; three others may take a walk around the building; and the remaining four or five may stay in the room to paint, play with water, sand or dough, or read stories. The infants, meanwhile, may be sleeping in the nap room.

Mainstreaming at the Family Center

Within its mixed-age setting, the Family Center is committed to providing a mainstreamed environment for differently abled very young children. Twenty percent of the children in the Center have cerebral palsy, spina bifida, Down syndrome, or developmental delays due to premature birth. A special educator coordinates special services, engages in the classroom with each child and teacher, and works closely with their families. She coordinates the Individualized Family Service Plan (IFSP) and the Individualized Educational Plan (IEP) for preschool children. An occupational therapist, physical therapist, and speech therapists provide services on site, most frequently in the child's classroom, so that the child's schedule is not disrupted by being removed from the group. By watching therapists in the classroom, caregivers learn new ways of participating in the child's development.

There is nothing mysterious or hidden about any child's disability. Children's questions are answered clearly and directly. "Nat wears braces to help strengthen his legs. He's not able to walk on his legs." Other children are often included in the work of therapist and child with a disability, as the following anecdote shows.

The OT is seated on the floor. Nat, aged 3.3, is in front of her, facing out. As she works on positioning his legs, she plays a make-believe game with him that involves a group of animal figures. In the game, the pig is hungry. Nat says he can have spaghetti and meatballs. A child sitting nearby joins the game. She and Nat decide to have a meatball party and invite the bear. Tom 2.6, and Rosie, 2.0 months, are absorbed in watching. As the play develops, the OT continues to position Nat's legs.

The children who are mainstreamed engage in all the activities offered at the Family Center. Wearing his leg braces, Nat crawls to the activities he chooses and plays freely with other children. Totally integrated into the group, he is a verbal, delightful three-year-old and a devoted block builder.

Family Center staff have had to learn to empathize with differently abled children without feeling sorry for them. This process has involved a growing awareness that caregivers cannot permit the children with disabilities to insist that other children conform to their limitations. For example, although some children enjoy crawling along with Nat, at some point their game will come to an end. The others will run off or climb up to the loft. The child with cerebral palsy is left behind, unable to participate. The staff must be supportive and straightforward in helping him come to terms with his situation.

This is a challenge for the staff. "We give Nat options," explains Karen Chaglasian, the special educator. "If he agreed, we would pick him up and run with him, holding him down at the level of the other children. Or we might ask if he wants to ride a scooter to go fast with the others. We don't point out what he can't do-he already knows that."

"All the children have options," Chaglasian continues. She describes an instance in which a group of children including Gayle, who was in a wheelchair, were painting each other's legs with water. The children were unable to reach Gayle's legs, so they painted the wheels. "All the children had a choice of how to adapt and continue the play."

The caregiver's experience in a mixed-age setting: Staff reflections

Family Center staff enjoy the challenge of planning materials and activities that are appropriate for the wide age span in their groups. They rely on open-ended materials

with a wide appeal. Amy Flynn, a head teacher, believes that using water, paint, sand and dough "helps you understand the many ways a material can be used, above and beyond your own adult conception."

Staff must be able to shift focus. They must consider the approach to use when the whole mixed-age group is together. They must be able to work in small groups, sometimes with children the same age and sometimes with mixed ages. Above all, they are challenged to think about individual children—apart from the group and developmental issues. Consistent and well-conceived staff development is important to help caregivers take advantage of the setting's great potential for learning. Laura Guarino, the Family Center's director, notes the need for constant communication, throughout the day, between herself and staff members.

"I would never go back to caring for just babies, as I did in my former job," says Barbara Abel, a head teacher at the Family Center. "You can't give the individual attention to three or four babies that you can to two babies." Still, the need to assure babies' safety is a real challenge. Infants must be protected from all sorts of physical danger (including the temptation to taste crayons, paint and glue) as well as jealous or curious toddlers.

Abel enjoys the wide age range at the Family Center. She loves to see the two's beginning to emulate the three's. Even a range of three months to 15-18 months seems too narrow to Abel

because the developmental issues around autonomy are so pressing for all of them there are no older children in the group with some developed controls to provide a balance. You're dealing with all the same developmental issues at once, and because the young toddler's conflict is between being a baby and being big, the babies often become their targets.

She finds little biting and hitting in the mixed-age group. When older children help the younger ones, they are doing what was done to them. The caregiver provides a consistent example, since she is with the children over a long period of time. She has seen them go through varying developmental phases and knows them very well.

Parent reflections

When prospective parents visit the Family Center, Laura Guarino describes the commitment to mainstreaming and mixed-age groups. Before parents see the classrooms, she prepares them and guides their observations toward the children's interactions.

Occasionally, a parent of a two-and-a-half- or three-year-old child in the mixed group will ask if the child is bored. Observing the child in action and talking with the teacher usually allays the parent's fears. Sometimes a parent will worry that the two-year-old who was just weaned will "fall apart" seeing one-year-olds with their bottles. Ms. Guarino reminds the parent that "development isn't linear. If children backtrack a little, they'll still move forward." Parents who do chose the Family Center are enthusiastically supportive of the program. They especially like the chance to build a continuing relationship with the same teachers over two years.

In sum...

The mixed-age, mainstreamed Family Center is a place where children, staff and parents grow and learn together. It is a setting that respects and embraces individual differences as the zest of life.

References

Brownell, CA. 1990. Social skills in toddlers: Competencies and constraints illustrated by same-age and mixed-age interaction. *Child Development*, 61, pp. 838-848.

Dunn, J and Dale, N. 1984. I a daddy: Two year olds collaborate in joint pretend with sibling and with mother. In I Bretherton (ed.) *Symbolic play: The development of social understanding*. New York: Academic Press.

Eckerman, CO, Davis, CC and Didow, SM. 1989. Toddlers' emerging ways of achieving social coordination with a peer. *Child Development*, 60, pp. 440-453.

French, DC. 1984. Children's knowledge of the social functions of younger, older and same-age peers. *Child Development*, 55, pp. 1429-1433.

Goldman, JA. Social participation of preschool children in same- versus mixed-age groups. *Child Development*, 52, pp. 644-650.

Hartup, WW. 1975. The origins of friendship. In M Lewis and L Rosenblum (eds.) *Friendship and peer relations*. New York: John Wiley & Sons.

Hignett, W and Rossiter, D. n.d. *Day care: What form it should take*. Pittsburgh, PA: Louise Child Care Center.

Howes, C. 1988. Peer interaction of young children. *Monographs of the Society for Research in Child Development*. Serial No. 217, 53:1.

Howes, C and Stewart, P. 1987. Child's play with adults, toys and peers: An examination of family and child-care influences. *Developmental Psychology*, 4, 23:3, pp. 423-430.

Katz, LG, Evangelou, D & Hartman, JA. 1990. *The case for mixed-age grouping in early education*. Washington, D.C.: NAEYC.

Koenner, M. 1975. Relations among infants and juveniles in comparative perspective. In M Lewis and L Rosenblum (eds.) *Friendship and peer relations*. New York: John Wiley.

Shapiro, E and Biber, B. 1972. *The education of young children: A developmental interaction approach*. Teachers College Record, 74, 55-79.

Vygotsky, LS. 1978. Mind in society: *The development of higher psychological processes*. M Cole, V John-Steiner, S Scribner, and E Souberman (eds.) Cambridge, MA: Harvard University Press.

5

The Center for Infants and Parents at Teachers College, Columbia University: A Setting for Study and Support

by Annette Axtmann, Ed.D.

John was seven weeks old when he and his mother appeared at the Center for Infants and Parents at Teachers College. We could barely see the top of his head poking up out of an infant sling wrapped against his mother's breast and behind a huge cart covered with video equipment which she wheeled before her into our office. John's mother appeared tired, yet eager to resume her graduate studies in educational technology and, at the same time, have John near her as much as possible.

This poignant image of John, his mother and the video equipment stays with us as representative of a population of parents with very young children attempting to manage home, school and career simultaneously. They are increasingly visible at Columbia University. Their requests for on-site infant care presented us with an opportunity to serve them and, at the same time, develop an interdisciplinary setting in which university students are able to engage in practice and observational studies which prepare them for research, educational and clinical work with very young children and their parents.

To ensure a comfortable balance between our service to families and our responsibilities for professional preparation, research and outreach activities, we place highest priority on the support and strengthening of relationships between infants and parents. This criterion is based on our understanding of the parent-child relationship as the crucial context for human growth and development in the earliest years. It guides decisions made on an ongoing basis within our developmental approach, which recognizes that students, parents, infants and faculty learn from one another and grow together.

Enrollment is on a first come, first served basis for parents who are students, staff or faculty at the University and whose baby is between 6 weeks and 24 months of age. Three staff care for 8 babies at a time in the Center, with each staff member responsible for observational and caregiving work with 2 or 3 families. One staff member is assigned as the child's primary caregiver and attends the first developmental visit with the parents, the baby, and the director.

Programs for infants and parents

Several unique features of the Program for Infants and Parents allow us to be responsive to individual and changing needs of our families:

- developmental visits which are part of the enrollment, ongoing participation and exit processes we are developing with our families;
- a flexible schedule of child care; and
- interage grouping of children 6 weeks to 24 months of age.

Developmental visits

The developmental visits and our flexible schedule of child care work together to help the parents clarify their feelings and needs in relation to their careers, to provide the staff and the parents with concrete information concerning the child's developmental process and, most importantly, to encourage the parents to work with us on a reciprocal basis. In addition, the visits yield vivid images of the way parents and children interact with one another. Since observations of the visits are collected in writing and on video tape by staff and other students working with the director, visit records, with informed consent of parents, become part of a data bank for research purposes.

Guided by pediatrician Martha Leonard of the Yale Child Study Center, we use developmental materials and tasks as well as questions about a child's history in what we call a "developmental observation." The director is responsible for the observation with the help of the parents, the child and the child's primary caregiver. Similar visits for purposes of updating information about development are scheduled as requested or needed throughout a family's participation in the Center.

A second visit of each family to the Center is providing invaluable in our work. It is designed to give the child's primary caregiver and other staff members an opportunity to observe the interactions between parents and child which occur naturally on a day-by-day basis. One or both parents, the child and the child's primary caregiver participate in this visit. The caregiver explains that she wants to learn from the parents how to care for the child before the child enters group care and may suggest the parent show the child areas and materials in the comfortable, well-furnished infant parent room. The caregiver role is that of participant-observer and does not involve intervention unless the situation becomes uncomfortable. We have found that this visit also provides information about the ways in which parent and child interact, their modes of communication and the degree of harmony in the way they adapt to one another. It is therefore helpful in interpreting their behavior later on. We have also found that imitating the parents' caregiving techniques can ease the child's first days in group care.

A flexible schedule of child care

Regular child care hours range from one day a week for 6 hours to 4 days a week for 5 hours to 2 days a week for 8 hours each day. The Center is open for child care 7 hours a day, 4 days a week during the academic year. The 7 hours shift slightly from semester to semester depending on a needs survey of currently enrolled families run at the end of one semester in preparation for the next.

Our flexible schedule of child care begins with an adjustment period during which we provide the parents with child care hours as close as possible to those they request, with the understanding that these hours may or may not be the best for their child or for them. While experiencing their first separation from their child on as near to their own terms as possible, parents have an opportunity to refine choices about the time they will spend pursuing their careers, caring for their child themselves, and being together as a couple, as well as about the kind of supplemental child care they find most comfortable.

It is the child's openly expressed reactions to the new experience which most strongly influence the deliberations and final decision of parents and staff regarding the regular schedule of child care hours. In the case of one family, the adjustment period lasted one day, since neither child or parent seemed discomfited by the separation from one another on the first or subsequent days. The adjustment of another family took 6 weeks, with several changes in both days and hours from the ones originally requested by the parents.

The baby is introduced into group care by her or his primary caregiver, who works individually with the child while other care-

givers first come to know the child from a distance. Gradually, as indicated above, the care of each child is shared by 2 or 3 caregivers. This systematic sharing is necessary because our caregivers observe and work no more than 10 hours per week with the babies and their parents. The balance of their time during the week is spent attending classes which occur at different times at the University. It is quite possible that the enthusiasm of our caregivers for their work—i.e., lack of the usual "burn out" experienced—is due to our flexible, limited caregiving schedules as well as the relationships we help them draw between the work and their studies.

Interage grouping

Our interage grouping of infants 6 weeks to 24 months of age makes it possible for us to admit families at a time in the child's life when many parents seem to feel a strong need to resume work outside the home yet lack societal support to do so. Interage grouping allows us to maintain a small operation, in keeping with accepted standards for quality group care of infants, and, at the same time, to serve a family for up to 18 months. It also provides a family-like setting where very young and older babies can interact with one another. Our systematic observations indicate that interactions between children ranging in age from 7 weeks to 24 months are often mutually facilitative in nature. One study focusing on interactions among parents, children and caregivers in our group care facility describes "an ethos of familial conviviality."

Additional studies and questions

Additional studies conducted by the staff and non-staff students working with the director have included topics such as separation issues in day care settings, infants and temperament and a study of the relations between two siblings who attended the Center at the same times. Data are also being gathered for a survey study related to the well-being and productivity of older parents who are attempting to work, study and rear their infants.

Information gathered through individual studies, research projects and the day-by-day observational work of the staff is shared with the parents as it is developed and in completed form. Parents who enroll in our program for infants and parents do so with the understanding that they and their baby will participate, within clearly specified limits, in our study and outreach activities. Recently, we invited some of the parents to join the staff in presenting the Center's work to conferees at the College.

Work in our Center for Infants and Parents has suggested several questions with important implications for practice and further study. We have observed in many of our parents a remarkable capacity to grow and learn with their babies in individual ways, day by day, as we work with them. Is this capacity related, in part, to the fact that they come to us for help with the care of their baby at a stressful time in their lives, when they are struggling to manage work, study and home? If so, others designing programs to support families might wish to incorporate aspects of our program, such as the opportunity for parents to choose and experience the times for child care that seem to them the best for their individual needs and to respond as fully as possible on an on-going basis to the expressed needs of the particular population. We feel these aspects encourage our parents to make thoughtful and realistic decisions basic to the development of family relations.

Another area for investigation is the potential for human growth, particularly the growth of empathy and social competence, in infants 6 weeks to 24 months of age, who are grouped together on a day-by-day basis. Systematic study of individuals who have this experience when they are young can yield implications for developmental theory and practice, particularly as programs for infant toddler group care expand to meet parental demand.

These and other questions which occur to students, parents and faculty as we work together with infants permeate and bring daily excitement to the active yet academic atmosphere of the Center for Infants and Parents. We cannot help but be optimistic about the potential for service of clinicians, educators and researchers trained in this atmosphere, where study is a part of practice and the quest for further knowledge becomes a key ingredient of teaching and caregiving.

The Center for Infants And Parents: Two Family Portraits

David

David, dark-haired with delicate features and blue eyes, was 7 months, 22 days old when he, his mother and father came to the Center for the first of two visits which would precede his enrollment in the Center for regular child care. David's parents, recently arrived in the U.S. from the Middle East, seemed extremely eager, almost desperate, to enroll David in the Center's program so that they might have more time to work on their doctoral studies at Columbia University.

David smiled at his primary caregiver from his stroller and appeared comfortable in his parents' arms. In discussing his feeding schedule his parents said: "He is not well organized." They told us he did not use a bottle and so when his mother went to the library and his father cared for him from noon until around 5 in the afternoon, he drank juice from a cup and was fed soft food with a spoon. He nursed off and on during the balance of the day and night. When asked, the parents could not describe differences between his cries according to the situation or his specific need at the time. This, and David's feeding pattern, seemed unusual to us. On the other hand, David responded to most of the tasks included in the developmental observation at or above his age level. For instance, toward the end of the visit a cloth was placed on David's head by one of his parents. He pulled it off quickly, smiling with delight. Evidently, peek-a-boo was a game they played together.

David's mother brought him to the infant-parent room for their second developmental visit. During this visit, David, his mother and his primary caregiver were sitting on the floor several feet away from a large colored mobile. David gazed toward the mobile and lifted up his arms in a gesture which seemed to say "take me up." His mother did not respond to this gesture but kept on talking to David's caregiver. David put his arms down, crawled past his mother until he was directly under the mobile, and whined. As he did so his mother got up from the floor, went toward the shelf across the room, took the "rockaring" toy from the shelf, brought it back and placed the toy on the floor beside David, commenting, "He has one at home and can work it." David grabbed a ring from the center of the "rockaring" while at the same time he continued to gaze upward at the mobile. Mother turned back to her conversation with the caregiver. Later, the two women got up and walked across the room, leaving David behind on the floor. His mother gave no indication of including him in this change of position. The caregiver, who must have felt uncomfortable at leaving David behind this way, invited David to "come over here." David watched them and cried out sharply. Then, he crawled energetically across the room after the two women.

All together, the two developmental visits yielded: a mother, father and baby newly away from their homeland who spoke little English; an unusual feeding schedule; and some lack of responsiveness to cues from the child, in that the parents did not seem to differentiate his cries nor read his gestures in ways that made sense to us. At the same time, we found a child who smiled happily in his parents' arms, displayed a good deal of energy locating and obtaining desired people and objects, and whose mother was seeking child care advice as well as relief from the daily care of her child.

The parents requested 7 hours of child care, 2 days a week. As with other families, we agreed to try these hours during their adjustment period. On the first and subsequent days, David refused to eat food or drink the juice offered to him by his father. As soon as his father left the infant parent room, he cried in a way that seemed to us to lack communicative quality expected of babies 7 months of age. We could not console him and he appeared unable to console himself, i.e., he did not resort to his thumb, had no "blanket" or other transitional object, and would not relax into sleep when pushed about in his stroller. His parents responded to this state of affairs by shifting their work hours so that David's mother, rather than his father, brought him to the Center. She stayed with him for several seven hour periods, nursing him from time to time and watching his primary caregiver with him. She asked questions, e.g., "How do parents know when a baby's ears hurt? ... older babies probably tell them." The caregiver responded: "Babies have other ways, such as tugging at their ears." During this period we observed David's mother lean way over on her side so that her face was level with his as he manipulated 2 colored rings. In contrast to her lack of response to his gestures of interest in the mobile during their second developmental visit, she seemed to be trying to take his perspective of the rings.

Despite this intensive work by mother and caregiver, David cried, invariably, when his mother slipped out of the infant-parent room for a short time. Therefore, we asked our clinical consultant to observe mother and child together and meet with David's parents. Among other things, the consultant suggested we change David's hours to 4 days a week, 4 hours at a time, instead of 2 days a week, 7 hours at a time. Although we followed her advice, we experienced no real change in David's behavior.

We did experience a change, however, after David's mother initiated a slightly new feeding pattern for him. Instead of nursing him at home she waited until they arrived at the Center. Upon arrival, she fed him fruit sauce and nursed him. When she left the infant-parent room he did not cry. Instead, he began to whimper and cry when the 4 hours were just about up and it was time for her to come to the Center, nurse him there and take him home with her. We were struck at this time by the seemingly intimate relationship between where and when David nursed and his ability to manage on his own without his mother for a more or less regular interval of time.

David began to enjoy his time in the Center more and more. Toward the end of his 6th week with us he was observed in a high chair feeding himself raisins as he watched his primary caregiver manipulate a "pop" umbrella. She asked David; "where did the man go? ... where ... there he is ... peek-a-boo." Later, the same caregiver stepped over the gate out of the infant-parent room while David stood, hanging onto the gate, watching her go into another room. A few seconds later, he dropped down and crawled back into the infant-parent room toward four other babies and another caregiver grouped together on the floor around a large bin filled with sand. This and similar incidents indicated that the staff of the Center, David's parents and David had found a regular schedule of child care hours suitable for this family.

One is never quite sure why a baby is finally able to cope with what appears to be a difficult situation. Certainly, David's general health, tenacity and curiosity about people and things around him as well as his parents' desire to achieve a satisfactory resolution of their child care needs, eagerness to learn from the staff and clinical consultant, and willingness to adjust their own as well as David's schedule were very important in the progress made by his family.

John

John was seven weeks old when his parents brought him to the Center for their first

developmental visit. His mother appeared very tired. She kept saying, "I have to leave soon . . . have a class." His father, a lawyer, seemed less ambivalent about the situation. John's mother took him out of his "Snuggli," removed a pacifier from his mouth and placed him on his back on a quilt spread out on the floor. He stretched out his legs and gazed upward. During the developmental observation he smiled radiantly at his primary caregiver. He did not hold the rattle in his hand as one might expect from a child his age, but did grasp the director's hand when she hooked it in his and looked into his eyes. John's responses were clues to us that his seeming delight in people could help us engage him in the developmentally useful gentle physical exercises (such as "pull to sit" and "bicycle") which occur naturally at the changing table. As the parents, director and primary caregiver became more involved watching John respond to the developmental tasks during the visit, his mother seemed to relax a bit. Toward the end of the visit, she nursed him. She said no more about going to class, but stayed the entire time required for the visit.

We began John's trial period immediately after the first visit with a tentative schedule of 3 days a week, 7 hours a day as requested by the parents. In contrast to David, we settled on these as the regular schedule of child care hours for John, after a four-day trial period. We did so because John gave no indications of distress when his parents left him in the infant-parent room without them.

During subsequent weeks John's mother gained physical strength. She would leave her baby with us and go to the library or class close by. Later, she would run up after class to nurse or play with John and talk to the caregivers. Toward the end of the semester the family had arranged a weekly schedule whereby the parents shared the caregiving of John on a regular basis, and also spent time together as a family and as a couple. John's mother had a part-time job in the mornings and was pursuing a doctoral degree at Teachers College through two evening courses. One evening at about 6:45 she came striding down the hall toward the Center. She was glowing with anticipation, saying, "I really missed him!" And later, as she pulled on his snowsuit, she said, "I really like him!" It seems John's mother had sorted out some of her needs and was managing with a degree of zest.

As for John, he responded to the physical exercise and special toys staff designed and made for him as if enjoying his interaction with us. Later, this enjoyment grew to encompass the other babies, with aplomb and enthusiasm. John is now 20 months old and has manifested no more than an occasional and fleeting sign of discomfort at separation from his parents. As his mother said, "The Center is a second home to him."

6

Therapeutic Childcare at Merrywood School

by Maxine Siegel

Infants and toddlers who are disabled or at risk of developmental delay are also highly vulnerable to abuse and neglect. How can we best meet the needs of these children and their families?

Although early childhood educators and childcare workers have often been overlooked as resources for this population, in fact an appropriately staffed and individualized therapeutic day care program can offer unique opportunities to protect and support such children and families.

Merrywood school in Bellevue, Washington has served developmentally disabled infants and toddlers and their families for more than a generation, under the auspices of the state's Division of Developmental Disabilities and Crippled Children's Services. We felt that our expertise would make it relatively easy to serve abused and/or neglected children of the same age, and in 1984 we responded to a state of Washington Division of Children's Services request for proposals. The result is Therapeutic Childcare, a program designed for abused or neglected children who are referred by Child Protective Services in order to keep the family intact, protect and nurture the child, and counsel and closely supervise parents.

Only ten children are enrolled in Merrywood's child care program. A maximum of eight are scheduled to attend on any given day. Of these eight, four are non-handicapped and four are developmentally disabled. Because it is desirable for young children with mild impairments to be enrolled in community daycare, the developmentally delayed children enrolled in our specialized program are moderately to severely involved. Three child care staff members serve these eight children, two staff at any given time.

Only three of the eight children, who can be either non-handicapped or developmentally delayed, are Child Protective Services referrals for therapeutic day care. Since the families of abused or neglected children tend to be dysfunctional, loading the full day program with such children overly stresses staff. With an amalgam of children's abilities and levels of family functioning represented in the program, however, staff can give the attention they feel necessary to the potentially abusing/neglecting parents and maintain other levels of interaction with better functioning families of handicapped or non-handicapped children in the group. Staff are also more able to respond to the demanding daily care needs of therapeutic day care children: these may include attention to diaper rashes, bathing, monitoring illness, feeding and coping with behavior problems. Most importantly, however, all parents and children in the school serve as incidental models for one another across the boundaries of disabilities, family characteristics, and ages.

The three therapeutic child care students are each enrolled five days a week in day care. They attend from six to ten hours per day. Because the full spectrum of special education and counseling components is

available, therapeutic day care participants may be involved in whatever menu of services seems most appropriate and for whatever frequency, intensity and duration seems indicated. Children use the *day* care classrooms at Merrywood as *home* base for naps, meals and "down time." They then go from there to whatever classroom or therapy services are in their plan. This model provides both consistency of staffing and flexibility to choose among program components. The Merrywood School program also makes an effort to match parents' needs with particular staff talents.

We encourage parents to bring their children to school because they can then spend some time in the program, speak with school staff informally, and again meet other parents in the school. Because non-day care children come to Merrywood for specific classes or therapy only, many families relax in the parent lounge, observe class from a one-way mirror, and chat with one another. When therapeutic child care parents join them, they benefit from the casual modeling of appropriate parenting techniques: separating from children at the beginning of the school day, greeting them after class, behavioral modification, even supervision in the parking lot and use of car seats. They are able to see what toys, skills, and activities are appropriate for their children and get a great deal of positive feedback from staff. When parents do not transport their children, staff do so in private cars equipped with car seats. They send notebooks back and forth daily with progress reports, art work, and generous praise for both parent and child; parents say they are eager for the feedback.

Merrywood also assigns each therapeutic day care family to a case manager. To avoid overstressing any one professional, this role is divided among staff and is not the responsibility of the hands-on child care worker. A social worker serves as the key contact with one family; a second is served by his classroom teacher and a third by the program coordinator. These professionals meet with families at least weekly to discuss behavior management, child development and other issues. They are also the principal liaisons with Child Protective Services, Public Health physicians, and other resources.

Case vignettes

The program for the A's, whose developmentally delayed year-old son Philip exhibited failure to thrive and severe eating problems, involved attending hour-long therapy sessions twice weekly with their child, meeting with the social worker weekly, playing with their son daily on the Merrywood grounds, and several days of volunteer work each week in her son's special classroom for Mrs. A. Philip was enrolled in day care while living with foster parents, and the parents' daily visitation was supervised at Merrywood. Because feeding was such an enormous problem, the A's initially came in at meal time to work with staff in feeding Philip. We soon noticed, however, that this was too stressful a period for both child and family. We backed off, let staff feed the child and encouraged Mom and Dad just to come and play daily—a far less anxiety producing and more reinforcing activity. Gradually the parents increased their involvement and learned new skills and Philip returned home. Today he is still enrolled at Merrywood, but in the developmental disability program, rather than in therapeutic day care. We continue to monitor his health and development and to provide physical and speech therapies as well as special education. After an initially hostile response to the program, his parents worked hard and were extremely cooperative. The medical and social service community and an excellent foster family also did their parts to achieve this success.

George is the developmentally delayed year-old son of mildly retarded parents. His program consists primarily of daily special education classes and consultant therapy services. His family's program emphasizes meetings with a classroom teacher weekly

at home or at the school. Parents also attend monthly all school parent education discussion sessions. Mr. and Mrs. B have been extremely cooperative and have made excellent progress. A teacher has worked with them in the home on such basics as how to arrange toys, how to play with their son, what is normal behavior for a two-year-old, what are reasonable expectations, and effective behavior management techniques. Together they have gone through their toy box and chosen what is appropriate for his age. A great coup occurred recently after little George had broken a prized piece of china; his mother noted that her instinct was to hit him, but instead she "timed herself out" and walked away. Both parents have asked staff for retorts to friends who urge them to spank their son. They are now able to reply that "for George that won't work, so we do it this way." The family, who used to refer to their child as "rat" or "monster," has begun to enjoy finding new positive pet names for George.

John was physically abused and entered the therapeutic day care program after hospitalization for hematoma and resulting hemiplegia. Fortunately he has no lingering disabilities as a result of his trauma, but he demonstrates a number of neurological "soft signs" and without intervention would likely become one of the many at-risk infants and toddlers who later develop school problems. He has been assessed by physical and speech therapists and spends two hours daily in the special education preschool classroom (with consultant therapy services) where he now functions as one of two non-handicapped models. His father, primarily responsible for the abuse, has left the family. However his mother is extremely neglectful and the situation requires constant supervision. Mrs. C. brings John to the program but has done little else to comply with Child Protective Services or Merrywood suggestions. School staff are carefully feeling their way to insure maximum care and protection for the child while interfering as little as possible with the family's very fragile bonding/attachment process. We are endeavoring to gain Mrs. C's trust, but at this stage she cancels or is not home for home visits by staff and spends as little time at school as possible. We are keeping in mind Crittenden's observation (1983) of a paradoxical effect of mandatory daycare. Rather than offering respite to overly stressed families, the separation involved in day care can interfere with an already tenuous attachment process made problematic by earlier separation experiences such as foster care. To avoid exacerbating family rejection, agencies must treat the family unit, not merely the child, and work to gain the trust of families and involve them in their child's program.

Bibliography

Barber-Madden, R. "Training Day Care Program Personnel in Handling Child Abuse Cases: Intervention and Prevention Outcomes." *Child Abuse and Neglect* 7 (1983): 25-33.

Crittenden, P. "The Effect of Mandatory Protective Daycare on Mutual Attachment in Maltreating Mother-Infant Dyads." *Child Abuse and Neglect* 7 (1983): 297-300.

Field, Tiffany. "High Risk Infants 'Have Less Fun' During Early Interactions." *Topics in Early Childhood Special Education* 3 (April 1983): 395-402.

Gabinet, Lailie. "Child Abuse Treatment Failures Reveal the Need for Redefinition of the Problem." *Child Abuse and Neglect* 4 (1983): 395-402.

Lero, D. "Early Childhood Educators: Their Contact with Abused and Neglected Children." *Child Welfare* 59 (March 1980): 169-178.

Roberts, M. "Reciprocal Nature of Parent-Infant Interaction: Implications for Child Maltreatments." *Child Welfare* 58 (June 1979): 383-92.

Yates, A. "Predicting the Abusive Parents' Response to Intervention." *Child Abuse and Neglect* 7 (1983): 37-44.

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Child care for infants and toddlers with special needs

7

"The Sooner the Better Project": Involving Parents and Day Care Staff in the Identification and Treatment of Developmental Delays and Disturbances in Infants and Toddlers

by Roseanne Clark, Ph.D. and Mary Jane Oltmans, M.A.

What happens when an infant or toddler in day care has undiagnosed, unmet developmental needs? First, the caregiver may experience difficulty—a child may require extra assistance, may withdraw or act out aggressively, may arouse feelings of frustration or ineffectiveness. Second, the parents, who may be experiencing similar feelings of inadequacy in their relationship with this child, may react to the "public" exposure of the child's problems in the day care setting by ignoring the problem or with increasingly negative feelings toward the child. Third, the child, perhaps coping already with negative experiences and frustration related to the developmental issues involved, may experience anxious, negative responses from adults both at home and in the day care setting.

At the same time, an infant-toddler day care setting has tremendous potential to serve as the source of screening, evaluation, referral, follow-through, and emotional support for very young children with special needs and their families. Day care staff observe children 8-10 hours a day, five days a week as they eat, sleep, play, get tired, get dirty, get upset and are comforted. Trained and experienced caregivers are not only in an excellent position to observe and identify children whose behavior and development are of concern, but they also have an opportunity in their daily interactions with parents to observe disturbances in early parent-child relationships.

The Sooner the Better project (TSTB) is an innovative initiative that was developed in response to the frustrations and expressed needs of day care personnel who recognized that developmental day care, while promoting the well-being of most children and families, was insufficient to meet the special needs of very young children experiencing developmental delays and disturbances, and the needs of their families. Day care staff could recognize problems but lacked the training to diagnose them and, more importantly, to develop treatment plans. At the same time, they knew that the lack of publicly funded programs for disabled and at risk infants and toddlers often meant that children, families, and caregivers would be forced to "wait it out" until the child became

three. TSTB is designed to tap the enormous power of caregivers, parents, and infant mental health professionals working together—within the day care setting—on behalf of the child.

TSTB is based in Baby Toddler Nursery, a child care program for children from four months to three years of age, sponsored by the Infant Welfare Society of Evanston, Illinois. Three-quarters of the 61 children enrolled are from low-income families. The center is not university based, but funded through a combination of public (Title XX) and private sources. Ratios of caregivers to children range from 1:4 for infants to 1:7 for two-year-olds.

The professional caregivers at the center come from a variety of backgrounds, with well over half living in the community served. Most have received their training at local colleges; all have completed some courses, and a few have earned an A.A. degree. Staff of TSTB—all working part-time on the project—include the director and assistant director of the day care center, a psychologist, a clinical psychology graduate student, and a social worker from the Community Coordinated Child Care (4C) agency.

Expanding professional competencies of infant-toddler caregivers

Initial TSTB efforts included an assessment of caregivers' knowledge of what delays and disturbances look like in children under three, what infants need to experience in their relationships with adults in order to develop optimally, and what problems in parent-child relations look like in the earliest years. Staff designed two in-service programs that focused on: 1) the psychosocial needs of young children in group care and 2) caregiving approaches for supporting development of communications and language skills. Some caregivers also attended a class on the exceptional child offered through the local community college.

Interestingly, we found that communication of information itself resulted in few referrals for evaluation by caregivers for the children in their charge. They told us of their concerns that a referral of, for example, a child with delayed language would reflect poorly on their own "teaching." Referral of a child exhibiting depressed, somber affect, on the other hand, might be seen as intrusive into the parents' "personal life." TSTB staff recognized the need to develop a relationship of mutual trust with caregivers, working with them individually or in teams in their own classrooms. This allowed us to understand better the caregivers' experience of the child and to communicate respect for their professional competence through collaborative efforts to observe, evaluate and plan for the child's special needs.

It has been continuous work around the needs of individual children that has contributed most to furthering development of caregivers' clinical observation skills, changes in attitude about infants' and toddlers' need for affectively involved and responsive care, and well-deserved professional pride in having observations respected and ideas incorporated into treatment plans for special needs children. We also saw caregivers generalizing new attitudes and patterns of behavior to their interaction with other children.

"Freeing up" caregivers

TSTB emphasized that caregivers needed to be allowed time to work individually with special needs children. This process allowed them to experience such a child in a new way—not just as demanding, but as needing special approaches. Caregivers experienced themselves in a new way as well—not only as making snacks, changing diapers, and picking up cots, but as being affectionate, responsive and interested in what an individual child can do, what he is trying to say. The program allowed time for responsive care. Caregivers were "freed up" also to spend time with parents, enlisting them to the fullest extent possible in planning and providing care for their child.

Clinical services research

In addition to TSTB's clinical services, a research component was begun this year in order to evaluate the efficacy of providing screening and making preventive intervention services available for all families with children under three in group care. Using data from a parental stress questionnaire, we will be looking at the relationship between parental stress and developmental delays and disturbances in this population. Preliminary data indicate good sensitivity and specificity for the TSTB risk assessment. Indications are that day care intake procedures that include developmental screening or assessment, along with inquiry about the level of stress and social support experienced by families, will assist day care staff in recognizing the special needs of infants and parents in their programs and the role that the day care program may provide in addressing those needs.

Two years with Brian

A description of TSTB's work with Brian and his parents suggests the benefits provided by this project for the child, for the family, and, no less importantly, for professional caregivers.

Brian was a healthy, active, curious and well-functioning infant until he contracted hemophilus influenza which developed into bacterial meningitis. He was eight months old at the time. A bright-eyed child with dark, wavy hair, he had just been enrolled in Baby Toddler Nursery when he became ill and was hospitalized for ten days. Returning to the nursery after two weeks at home, he was completely changed. Once robust and energetic, Brian was listless and sickly. Able to crawl and pull himself up to stand at eight months, at nine months he could not sit unsupported and had little control of his head and neck muscles. His organizational and self-regulating abilities had regressed, and his affect had become somber and depressed. Formerly friendly and affectionate, vocalizing and socially responsive, he now averted his gaze and arched away from comforting or cuddling. Perhaps most devastating, the results of a brainstem auditory evoked potential showed no response in the left ear and diminished ability to hear in the right ear.

While Brian made gains both physically and emotionally over the next few months, it became clear to day care center staff that complete spontaneous recovery was unlikely. The report from the developmental assessment conducted at 11 months by the center's consulting clinical developmental psychologist described Brian as lying on his back in the infant room when she came to get him for testing, his color grey or dusky, his affect dampened and somber. He appeared sick and listless. Brian was alert, however, and watched intensely the activity of the others in the room. Asked by the psychologist for their observations and experience of Brian over the prior few weeks, center caregivers described him as lying on his back unless held, often crying or wearing a distressed expression, and being extremely difficult to comfort. When they looked at him, he would quickly avert his gaze. They felt that he was fragile and needy, but they also felt that they didn't know what to do to help him.

Results of the Bayley Assessment indicated an MDI of 71 and a PDI of 58. Some of Brian's failures were on items requiring vocalization or auditory skills, and others required a higher energy level than Brian was capable of at the time. His psychomotor functioning was greatly impaired, and though he did demonstrate age-appropriate fine motor skills, the quality of his movements were of concern, with stiffening and arching noted. While Brian was quiet, wary and withdrawn when the assessment began, he appeared to be able to make use of the psychologist's holding him, and focusing his interest with quiet enthusiasm and positive affect did not overstimulate him. He was able to become more involved with the test materials. A very bright child, Brian was able to complete age level items that did not tax his physical energy level or require auditory

comprehension. He brightened when he built a tower of two cubes, and he became involved in reciprocal, responsive play with the psychologist.

By his first birthday, however, Brian still had a somber demeanor, had difficulty with head and neck control, and was able to sit unsupported for only brief periods. Most serious, he did not appear to respond to sounds or to spoken language.

Not surprisingly, it was difficult for Brian's parents to accept his disabilities. In contrast, it was difficult for daycare staff to understand and accept his parents' reluctance. While parents of a special needs child have very deep needs which are both emotional and practical, caregivers' needs are largely practical, having to do mostly with providing care and promoting development. In Brian's case, this difference was accentuated because the parents were coping with the loss of their healthy infant, while caregivers were emotionally involved only with the child he had become.

Since the initial evaluation, the extent and nature of Brian's hearing disability remain unclear. Audiograms and other tests have indicated borderline normal hearing (sufficient for speech development), but Brian continues to be unresponsive to spoken language. His parents maintain that he can hear and are determined that he use oral language exclusively. While they have cooperated in learning sign language, they primarily use spoken language in their interactions with him. Brian's speech therapist, on the other hand, wants him to learn sign language simultaneously with oral language, on the theory that sign language will provide him with more communicative ability more quickly, as well as giving him the construct of "language," which may help him to learn speech. Brian in fact has learned sign language quickly and uses it well, now teaching his caregivers new words. He can also initiate communication and express his growing autonomy: recently, in response to his caregiver's sign to sit, Brian vehemently made the sign for "walk."

To understand Brian's parents' perspective better, it is important to know that during the period of his illness and initial recovery they were also struggling to regain their equilibrium. They had just completed an interstate move and dual career changes when Brian became ill. Particularly for his mother, the loss of Brian as a healthy, responsive, competent infant was very difficult, and the experience of Brian as ignoring and uncooperative left her feeling frustrated and ineffective.

In the two years since Brian's illness, his parents have come to accept his disabilities to a significant degree. Their interaction with their son is far more positive and affectively attuned than formerly. He seeks comfort and approval from them, and they have come to be proud of his achievements, even in learning sign language.

Another dimension of this experience for Brian's caregivers was the opportunity for professional growth. Because of their work with Brian, they were receiving consultation from, and working with, other professionals. They were helped to understand Brian's needs, which in turn helped them to avoid feelings of rejection and frustration. They were given practical suggestions for structuring his environment and for helping to promote his optimal development. Relieved of regular caregiving responsibilities for short periods in order to work alone with Brian, they helped him learn that adults can be expected to be responsive. In many ways, their experience was one of personal and professional growth.

The role of the day care center as a whole through these two years has been five-fold: 1) providing a developmental clinical assessment of Brian's strengths as well as areas of compromised functioning; 2) assessing Brian's parents' resources, coping abilities, relationship with Brian, and personal needs; 3) carrying out therapeutic plans developed for Brian, especially around communication skills; 4) coordination of evaluation and services of a number of agencies and private providers; and 5) serving as a source of

interested, available, and empathic support for parents. This last function has included exchanging anecdotes about Brian and his accomplishments, listening to his parents' frustrations and triumphs, reflecting on and interpreting feedback from other professionals, problem solving, developmental guidance, and encouragement. The day care center has proven to be an ideal source of support, particularly because of the opportunity for daily contact between parents and professionals who have an obvious involvement with the child. Because contact is so frequent, it is at times casual. Because it is so readily available, it does not add another "appointment" to an already heavy schedule. The day care center supports both Brian and his parents in ways that more traditional services for infants and families facing developmental problems may find difficult to achieve.

8

Models of Integration Through Early Intervention/Child Care Collaborations

by Mary Beth Bruder, Ph.D., Penny Deiner, Ph.D., Sandy Sachs, M.Ed, LCSW

Families of young children with disabilities, like all families, have many roles and functions to fulfill. One of the most important functions is the need to work for a living. Infants and toddlers with disabilities, like people of any age with disabilities, deserve opportunities to participate in the typical experiences of their culture. Delivering early intervention services within community child care programs offers an opportunity to support the development of young children with disabilities and their families through the kinds of comprehensive community-based, family-centered services envisioned by P.L. 99-457. Yet the challenges of such a model to both the early intervention system and the child care system are many.

Connecticut, Delaware and Massachusetts are three states that have accepted this challenge. Each state is currently developing model early intervention programs within community child care settings. Each is using a combination of federal and state funds to provide a variety of services to enrolled children, families, and child care staff. This article, based on a symposium presented at the National Center for Clinical Infant Programs' December, 1989 National Training Institute, will describe activities within each of the three states and discuss issues of service delivery, training, policy development and evaluation which have emerged in all of the states' efforts.

Connecticut

The state of Connecticut has been allocating funds to train day care providers to serve young children with special needs for the past three years. The Department of Human Resources and the Department of Mental Retardation have been contracting to the Division of Child and Family Studies, Department of Pediatrics at the University of Connecticut for this training. The Division has also received a federal in-service training project (HCEEP), The Day Care Training Project, to develop a model curriculum on the integration of children with special needs into day care centers. Additionally the Division has two demonstration projects (HCEEP), jointly referred to as the Early Childhood Special Education Community Integration Program, funded to assist existing early intervention agencies (Department of Mental Retardation for children birth to three; Department of Education for children three to five) to expand their service delivery options into community day care settings and nursery schools.

Delaware

The state of Delaware has also been using both state and federal funds to train day care providers. Delaware First was a three year statewide demonstration project (HCEEP) designed to provide quality early intervention for handicapped and at-risk infants and toddlers in mainstreamed family

day care homes. Project designers recognized the potential of family day care, where six children or fewer are cared for in the provider's own home, to offer the individualized care needed by children with disabilities. A second goal of the project was to facilitate both formal and informal support systems for families by providing respite and a break from caregiving responsibilities for some families, while providing high quality child care for employed parents of young children with disabilities. The third goal was to increase the number of family day care providers throughout the state trained to care for special needs infants and toddlers. A second effort, Project Del Care, has used state P.L. 99-457 funds to expand this model to center-based child care programs.

Massachusetts

The state of Massachusetts is using P.L. 99-457 Part H funds from the Department of Public Health to support the Day Care/Early Intervention (EI) Collaboration Pilot, to develop day care/early intervention collaboration projects at four sites. Activities at each site include selection of children to be enrolled, joint child and family assessment, the joint development of Individual Family Service Plans (parents, day care and EI staff), establishment of a working partnership, defining the role of consultation for each program, working out role definitions to highlight the strengths of each service type and working closely with the 8 to 10 families participating at each of the four sites. Each of the four partner sites proposes to target children for these combined services who are at high risk for developmental delays due to environmental risk factors.

Although the model projects differ somewhat among the states, a number of issues recur as early intervention services are integrated within child care settings. These issues cluster around service delivery, training, evaluation, and policy development.

Service delivery

The identification of children who are eligible for early intervention services represents a service delivery issue in all three states. The projects currently underway that deliver early intervention within the child care setting are focused on young children who are already identified as eligible for these services. In addition, however, the Del Care Project (Delaware) and the Day Care Training Project (Connecticut) train child care providers to identify children in their programs who may be eligible for additional services.

The issue of who pays for early intervention services delivered within the community child care setting has been a central one in each state. Complicating this issue is the existence of very different traditions in paying for early intervention and for child care. Early intervention services for infants and toddlers with disabilities—where they have existed under state auspices and with Medicaid reimbursement—have typically been provided at little or no cost to families, regardless of family income. Child care, however, has generally been regarded in this country as the financial responsibility of the parents, although tax credits and some direct subsidies have eased the burden for some categories of families.

In Massachusetts, a fifteen-month Department of Public Health grant to each of the four participating day care/early intervention programs covers: 1) the costs of day care for 8-10 children per site; 2) the costs of transportation to the day care site; 3) costs of liaison activities by a designated member of the transdisciplinary team of each collaborating early intervention program; and 4) salary of a developmental educator or social worker for the day care program. The cost of specialized Early Intervention services is provided through the combination of state, federal and third party funding sources used by all 43 DPH Early Intervention Programs.

The Connecticut funding pattern reflects the conflict between early intervention and child care financing. If an early intervention team determines that an infant or toddler should receive early intervention services

within a community early childhood setting, the Department of Mental Retardation will generally pay for part-time participation in the child care program (for children birth to three). If parents wish to use the site for full-time child care, they must pay the additional costs. (The local Education Agency follows these same procedures for children age 3 through 5.) In addition to child care fees, the early intervention agency pays for whatever specialized services are outlined in the IFSP. These typically include direct services to the child or consultation to child care staff by a special education teacher and other professionals. In some cases, the costs of instructional aides and adaptive equipment have been covered. Transportation can be provided by an early intervention program bus or reimbursement to the family.

The Delaware system is still evolving. The Del First project paid the full child care costs for 21 infants and toddlers with special needs who were placed in family day care homes. The Del Care project, a center-based initiative, offered to pay centers' standard child care rates for children with special needs but found child care centers unwilling to participate on this basis. Recognizing the additional costs to child care programs for the extra planning and record keeping involved in participating in a demonstration project, Del Care now uses a sliding scale, with rates based on the additional effort required to serve specific children. All programs are given at least $50 a month for planning, record keeping, working with the project staff and implementing the child's IFSP. A provider caring for a child with an overall developmental delay receives an additional $100 a month; a program serving an extremely involved child who requires tube feeding and extensive stimulation might receive an additional $150.

The overall quality of caregiving within participating day care programs is another service issue within all states. When program quality is poor, the development of any young child, regardless of special needs, is affected adversely. Both Delaware and Connecticut use Thelma Harm's Family Day Care Rating Scale or Early Childhood Environmental Rating Scale to screen all potential child care sites. The Connecticut Early Childhood Special Education Community Integration Program uses an internally developed site selection tool.

Unfortunately, the high demand for quality infant and toddler child care far exceeds the supply across the country. Providers have a wide range of formalized training, observational skills, and ability to nurture and care for very young children. In center-based care, particularly, one needs to be alert to whether the quality and amount of individual attention provided is enough to meet the special needs of infants and toddlers with developmental delays or disabilities. Quality of care may vary greatly within a child care setting. Del Care project staff report the greatest diversity among one-year-old and toddler classrooms. Massachusetts currently provides a large system of subsidized day care for working parents and parents participating in educational and training programs. One infant care model being used is the "primary care" model where one caregiver is assigned to 3 or 4 infants or toddlers to promote consistency of care and bonding between caregiver and child.

When staff in the Connecticut and Delaware projects have felt that they are working, for lack of alternatives, with child care providers who are not offering high quality care, they look for opportunities to offer consultation and support. Good rapport (perhaps facilitated by monetary incentives) between early intervention and child care staff is essential. The fact that in the Del Care Project, project staff select the classroom for each child with special needs provides an opportunity to discuss with the child care program director the variability of quality between classrooms and ways to bring about improvements.

In all three states, staff turnover within both early intervention and day care programs is high, affecting the quality of chil-

dren's experience. Family day care homes have the most stable staff, however, the numbers of these placements (in Connecticut there are over 5,000) and the limited number of children within each (6) create a very large system to work with. It should be noted that the national turnover for day care providers is at 41% due to a number of reasons, primarily pay ($5.35 an hour nationally).

Training

Training is a primary service of early intervention/child care collaborative projects in all three states. Massachusetts provided funds for four staff of the statewide child care resource and referral network to receive intensive training regarding infants and toddlers with special needs. These trainers are now teaching a course entitled "Infants and Toddlers at Risk" at four sites across the state. Several of the trainers have chosen to co-teach the course with an early intervention educator and to include presentations by early intervention parents. The Massachusetts Office for Children sponsors this course and an "Infant/Toddler Development" course for college credit, offers workshops through the 12 child care resource and referral agencies, and this spring is sponsoring a conference to bring together day care and early intervention staff statewide. The Department of Public Health funds four outreach and training programs that provide training around child health and development issues. The Early Intervention Programs themselves provide child-specific services and training to child care providers around children enrolled in child care settings. Early Intervention staff are provided statewide training through the efforts of the Continuing Education Consortium for Early Intervention Programs and the Massachusetts Early Intervention Consortium (of parents and providers).

Both Connecticut and Delaware offer specific training courses to day care providers. Based on the principles of adult learning, these courses incorporate the concerns and needs of individual providers into the training. The activities of the Connecticut Day Care Training Project range from on-site workshops, to small group institutes of 5-7 sessions, to individual technical assistance. Not only is training free to child care providers, but additional incentives include meals for participants, money for substitutes and/or reimbursement for time spent in on-site training sessions, and continuing education credits.

Early intervention staff have also been the recipients of training through the Early Childhood Special Education Community Integration Program in Connecticut. The content of this training has revolved around early intervention service delivery with a focus on meeting each child's unique needs through team development and coordination with the child care program. The particular focus for the early intervention staff involved in this project has been on their accommodation to their changing roles as consultants to child care programs, and the development of new skills to fulfill this role. These skills have included communication, collaboration, and consultation skills, as well as the management and facilitation of service delivery teams. As with day care staff, the training of early interventionists has incorporated the use of ongoing needs assessments and the development of flexible, effective training activities which use adult learning principles.

All three states provide training to families of young children with disabilities. Families have been by far the most responsive and enthusiastic audience. Of some surprise was the extensiveness of family training needs. Most have requested training on basic intervention issues, including their rights and responsibilities under P.L. 99-457 and P.L. 94-142, types and goals of intervention services, funding and reimbursement issues and developmentally appropriate goals and activities.

A major training issue which has emerged from all three projects is the need for more on-site day care consultation, both on

general and child-specific issues. In Massachusetts and Connecticut providers of state-subsidized day care systems are requesting on-going, on-site training concerning the many children they serve who are experiencing developmental delays due to environmental factors.

Evaluation

All three states have evaluation plans to monitor their individual projects. Massachusetts is using a process evaluation for the 15-month pilot projects. The main goals of the evaluation are to document: 1) the development and process of program partners working in collaboration; 2) the integration of children into "normalized" settings; and 3) the impact of early intervention services in child care settings on children and families. The evaluation will include a parent questionnaire and a staff questionnaire. The providers will examine variables of family functioning, styles of parent-child interaction and social/emotional and behavioral adaptations of children, as well as assessing and marking children's developmental progress.

Delaware has focused on child change as one indicator of effectiveness. There are problems in this strategy, however. These have included the briefness of the intervention for some children, the difficulty in locating appropriate assessments for children with multiple disabilities, the time lag between initial assessment and placement within day care, and a general sensitivity to the problems of over-testing children. Delaware is also measuring the satisfaction with child care among parents of both children with disabilities and non-disabled children, and the environmental changes which occur within participating day care settings.

The training of day care providers in Delaware and Connecticut has been evaluated extensively. An issue which has surfaced has been the use of self-rating scales by the trainees. In both states, trainees rated themselves as knowing less after training than before. In both instances, it was documented that the training made providers newly aware of what they didn't know. Both projects are now redesigning their scales to insure a rating on the specific content of training.

In addition to the day care training outcomes, Connecticut has an evaluation plan which includes child impact (developmental change and behavioral change across a range of instruments), family impact (attitude, use of community resources and support systems, and satisfaction with training and project outcomes), and program impact (early intervention program profiles, early childhood environments and training outcomes). Evaluation outcomes are available on request from all three projects.

Policy development

This area will have the greatest long-term impact on the overall efficacy and usefulness of the early intervention/child care model. According to the Carolina Institute on Policy Development, policy refers to the rules and standards that are established in order to allocate public resources to meet a particular social need. Each of the early intervention/child care initiatives is working with state agencies and advisory boards to establish, refine and evaluate policies which facilitate this service delivery model.

In Connecticut, policies have been initiated within two state agencies responsible for direct early intervention services. The Department of Mental Retardation has revised its early intervention program philosophy to include a statement that "transdisciplinary quality early intervention services for infants, toddlers, and their families will be tailored to each family's needs and delivered in the home or in places that teach or care for typical young children." The Department of Education has focused on the delivery of preschool special education services within a range of least restrictive settings, including nursery schools and day care programs. Local programs have followed suit with changes of philosophy,

expansion of program sites in the community and the development of new practices. The advisory board to the Early Childhood Special Education Community Integration Program has been instrumental in developing local policies which include interagency agreements, bus training protocols, practices for "aides" on leave, and time for "teaming" and consultation with community early childhood programs.

An additional policy being investigated within Delaware concerns equalization of caseloads among early intervention staff. For example, a developmentally delayed child from a well-functioning family in a high quality family day care home is one child in the case load. Another child, also diagnosed as developmentally delayed, may come from a home with a single mother who is herself mentally retarded. The child also may have two older siblings in special education, no telephone, and be enrolled in a child care center of questionable quality. Serving these children well does not require equal amounts of time and energy. Child, family and setting variables are being taken into account in an attempt to address and equalize case loads.

In Massachusetts, funding of the collaboration pilot is an expression of a policy goal to expand access and support to child care for children with specialized needs. The approach to interagency policy development involves the encouragement of coordination of services at the local level, while simultaneously sewing a common thread of collaboration and integration through the many early childhood state policy, advocacy and advisory groups. Complementary state efforts include the current revision of the Special Needs Section of the Office for Children licensing standards, the revision of state teacher certification, the use of JEPTA and state Employment and Training dollars to train child care staff, efforts of the Child Care Resource and Referral agencies to assist parents and to recruit providers to serve children with special needs, and the development of a coordinated system of child find and developmental screening.

Conclusion

The states of Connecticut, Delaware and Massachusetts are attempting to expand early intervention service delivery options for infants, toddlers, and their families.

The integration of child care and early intervention services is appealing for a number of reasons. First, families with children with special needs want to be part of community-based support systems designed for all children and families. Second, the child who is receiving early intervention services will have the opportunity to learn, practice and generalize skills in a normative environment designed to support all aspects of his development. Third, early interventionists and child care providers will have an opportunity to learn from each other and collaborate on practices that will benefit all of the children enrolled in their programs.

Before model programs become replicated widely, many issues of service delivery, training, evaluation and policy development remain to be resolved. In Connecticut, Delaware and Massachusetts, parents, child care providers, early interventionists, trainers, administrators and policymakers are working together to realize the potential of integrated child care and early intervention services for children and families.

9

Social Development and Integration: Facilitating the prosocial development of typical and exceptional infants and toddlers in group settings

by Donna Wittmer, Ph.D. and Sandra Petersen, M.A.

Traditionally, children who spent their first three years of life at home with families learned about relationships within their family circle. Now, increasing numbers of American toddlers are being cared for in groups, away from their parents for large parts of the day. These include toddlers with disabilities for whom early intervention takes place in community-based settings such as child care centers or socially integrated play groups (Bruder, Deiner & Sachs, 1990; Gilkerson, Hilliard III, Schrag & Shonkoff; 1987; Hanline & Hanson, 1989; Klein & Sheehan, 1987; Newby, 1990; Turnbull & Turnbull, 1990).

Consequently, caregivers and early interventionists have an increasingly significant role in supporting the development of social competence in toddlers, both typical and exceptional. Toddlers who come to a group setting with early social skills will need ongoing support from caring adults to reinforce and strengthen those skills. We know that preschoolers with special needs show improved peer-related social competence when in socially integrated settings (Guralnick, 1990), *especially* when teachers promote positive social interactions between typical and exceptional peers (Odom & McEvoy, 1988). Children who come to group care from difficult early relationships may need very special care to even begin to feel comfortable around strange adults and other children and later to enjoy and learn from other children.

This article describes attributes which comprise the foundation of social competence in the toddler: 1) a sense of competence and self-confidence, 2) learning to trust and like others, and 3) the prosocial skills that come from learning "the other side of the relationship." The role of the caregiver in the development of social competence in toddlers with special needs in socially integrated settings is illustrated, and recommended strategies for promoting these attributes of prosocial interactions for all toddlers follow each section.

A sense of competence, mastery, and self-confidence

Jamal was thin and frail when he began attending the child care center. A few weeks earlier his first birthday had been celebrated in the hospital, where he was being treated for "failure to thrive." In Jamal's home, the adults were preoccupied with the effects of terrible losses and personal violence. During his first year no one

had time or energy for Jamal. By his second year, he didn't expect any attention.

At the child care center Jamal indiscriminately produced a flat smile and held out his arms for anyone who approached. Sometimes he would wander around carrying a toy in each hand, but giving the impression that he had forgotten they were there.

The caregivers recognized that they would need to help Jamal become aware of himself and his own needs before he would be able to enjoy the other toddlers. Although they were busy, caregivers found special times to feed him alone in addition to the group's snack and meal times. At naptime he was rocked to sleep in loving arms. Often, he sat quietly in the caregivers' laps, comforted by the closeness.

For several months there was little change in him. Then, slowly, from the haven provided by his caregivers, he began to express some of his feelings. He looked happy to arrive at the center.

As Jamal expressed more feelings, he began to act in his own behalf. He chose toys that he wanted and would give his caregivers a fleeting, proud smile while playing. He was interested in new activities. Sometimes he stood near other children, watching them, and smiling at their activity.

Having adults patiently learn about Jamal's feelings and his desires helped him begin to know himself and see himself as being able to make good things happen with other people.

In a young child's first relationships with adults the infant learns, "I am worthy of getting a response. I am someone important." An infant's feelings of self-worth and self-confidence grow each day when he is with a person who cares enough to try to understand what it is the baby is communicating and meet the baby's early needs for comforting and nurture. As infants make things happen, as they behave and get a prompt response, as they learn about cause and effect relationships in their first relationship with a special adult, and as their deep emotional needs are met, they gain a sense of competence and self-confidence. This sense of the infant that "I am important. I can do things. I can communicate. I can make things happen. I can get my needs met" is at the root of all motivation to interact with others. When an infant feels confident that he or she can get a response, then the infant is much more likely to attempt to interact with toys, peers, and adults.

Shareen picks up a toy and throws it at another toddler in her child care center. The teacher reprimands her. Shareen begins to follow the teacher.

At lunch time, Shareen sits, not eating her food. The caregivers discuss how she never eats her lunch and yet she always wants the dessert that follows. One caregiver reaches over the table and takes Shareen's plate and throws it into a large trash can. Shareen angrily gets up, comes around the table, picks up her plate out of the trash can, and throws it on the floor. Another caregiver picks it up and says, "I don't like that, that makes a mess on the floor." The caregiver sits on a chair and with gestures invites Shareen to come sit on her lap. Shareen approaches and begins to hit the caregiver on the legs. The caregiver says firmly but gently, "That hurts, I don't like you to hit, do you need a hug?" Shareen melts into the caregiver's lap for a hug.

This toddler, observed in a community-based child care center, has a difficult attachment history (Wittmer, 1991). She did not initiate interactions with peers. Rather she remained close to her special caregiver. When peers approached her, she rejected them. While quite ambivalent in her relationships with adults, it seemed as if she had to gain competence and self-confidence with adults before she could enter the world of peers. Luckily for this little girl, one of the caregivers understood and met the deep need that she seemed to have to be close, get hugs, and consistent caring attention from the special adult with whom she was developing a relationship.

Observed in a play group setting, typical toddlers with a good relationship history were seen as "attractive interactive partners" (Jacobson & Wille, 1986). These children

received the greatest number of positive responses from their peers as compared to toddlers with insecure attachment histories who were either uninteresting (with avoidant attachments) or disruptive, combative and resistant (with ambivalent attachments). They had greater confidence and effectiveness in dealing with objects and people. They were more interesting, and other children sought them out as playmates.

When infants do not feel that they can master the environment of people and objects, they may give up and avoid people, objects, or both—or interact with them in inappropriate ways. Children who have suffered early abuse, for example, are not well prepared for later relationships. Main and George (1985) observed that abused infants were much less likely than others to approach their caregivers in response to friendly overtures; when they did so they were more likely to approach to the side, to the rear, or by turning about and backstepping. In response to friendly overtures the abused infants more frequently avoided peers and caregivers or combined movements of approach with movements of avoidance.

These children require a reparative relationship with an adult. "It is only when relationships are recognized as the major issue that changes in the quality of care can happen that will make the day care of children more appropriate." (Pawl, 1990) It is essential that a child care provider or early interventionist attempt to fulfill the child's early, unmet needs for security by being a sensitive, responsive partner. The child may not easily accept the adult's overtures. The adult must be persistent and unconditionally available, realizing the importance of helping build the toddler's self-confidence in relationships with adult's first and peers later.

How applicable are these observations to young children with disabilities? Are toddlers with disabilities developing a sense of competence and self-confidence in relationships? If they have had a positive relationship with their primary caregivers during the first years of life, do they then have a sense of competence with peers? Are they sought after as interesting partners? We do not yet know the answers to these questions.

The parents of infants with special needs have been found to compensate and work harder at reading often subtle cues, so that they can comfort the infant and interact in positive ways (Minde, Perrotta & Hellman, 1988; Wasserman, 1985). This pattern works with the infant and his special caregiver. However, as the toddler with disabilities moves into the world of peers, she may have difficulty communicating her needs. Moreover, the young child's peers, both typical and exceptional, have fewer skills for compensating for the toddler with special needs than did his special adult. The child will need a sensitive, attuned adult to interpret her desires to interact with other children.

The caregiver also needs to teach other children how to compensate for skills that are lacking or emerging, and how to build on the strengths of the toddler with special needs, so that peers can enjoy each others' company. In a study of an integrated child care setting, only seven percent of the total positive/neutral interactions observed (Wittmer, 1991) involved the toddler with special needs as a recipient of initiations from other toddlers. And approximately half of the incidents of peers comforting, helping, or giving to toddlers with special needs in integrated settings occurred after the teacher requested the typically developing child to do so (Wittmer, 1991). (Interestingly, there was also only one occasion when a toddler with special needs was observed to be the recipient of any type of negative approach from other toddlers.)

Henry, a child with cerebral palsy, is carried by his caregiver to the midst of children playing with miniature balls in a wading pool. Propped in his teacher's lap, Henry watches Alex dive in and out of the hundreds of colorful balls in the pool. Several girls push some of the balls on Henry

and he smiles. After Henry watches for another five minutes, the teacher asks Allison to throw some balls to Henry. She throws a ball in Henry's direction and the teacher then assists Henry in throwing the ball back to his playmate. They take several turns, as Henry smiles.

Henry gave positive feedback to his peers who were playing with him. Other young children with special needs may not. In a population of typical toddler peers, the ability to initiate appropriate prosocial overtures appeared to exceed their ability to respond in a manner to sustain the social interaction (Bronson, 1975). Wittmer (1991) found that several toddlers with special needs avoided, ignored, or cried when other toddlers tried to interact with them. All toddlers, including toddlers with disabilities, need special help in knowing how to respond to another toddler's initiations.

Learning to trust and like others: Wanting to be social

Trevor was the first child with a disability to attend the child care center. Trevor had Down syndrome. At the age of 18 months he crawled, and he didn't use any language.

Because of their own ideas about his disability, Trevor's care providers perceived him as being fragile and in need of protection from everyone and everything in the environment. They kept him away from the other toddlers, strapped him into an infant seat at mealtimes, held him on their laps during play times, and had him napping in an anteroom, so that the other children "didn't bother him".

Trevor was very lonely in child care. He was about to teach the child care providers about the impact being around other children can have on a child. The toddlers in the classroom did interesting things nonstop. They ran from one side of the room to the other, challenging each other with a look to join in or keep up. They copied each other's table banging and screaming, making them louder with each imitation. They carried toys everywhere.

As Trevor watched the other children playing, moving, and singing he became

Strategies for helping children learn self-confidence in relationships and developing children's self esteem:

1. Respond quickly and sensitively to toddlers' expressed needs so they will feel secure and important and gain self-confidence in learning how to communicate their needs.
2. Make sure that each child builds a strong, positive relationship with at least one adult in the room. Infants and toddlers need a secure base to which they can return for comfort, an adult from whom they can learn that they are special.
3. Give particularly attractive toys to the child with disabilities or the child who is having difficulty with peer interactions, sometimes letting that child use a new or seldom offered toy. This will help make the child a more attractive play partner and develop the child's sense of competence.
4. Raise the status of the child with disabilities by your own loving, welcoming attitude. Say, "I love sitting next to Ting-Ting. She gives me big smiles."
5. Use books in the classroom that show children and adults with disabilities in a positive light. Read stories about children with special needs. This will help toddlers with disabilities develop a sense of self-worth and typical toddlers understand disabilities and see the strengths of exceptional toddlers.
6. Use posters in your room which show children with disabilities participating in daily activities with other children.
7. Interpret the sometimes subtle cues of children to other children. "He said, 'Hi.' Say 'hi' back," or "She's really looking at that doll. I think she wants that doll." Another way to interpret is to "talk for" the child with disabilities, saying "Sarah wants to help with those blocks. She says, 'I want to play, too!'"
8. Find some way for the child with disabilities to communicate. If he/she cannot speak, you might try sign language, pictures, or communication boards.
9. Enhance the competencies of children with disabilities by: providing room for strollers, wheelchairs, or walkers between all activity areas; providing toys and activities within reach from a stroller or wheelchair; providing adaptive furniture that allows the child to participate in an activity such as art; adapting toys with switches for a severely physically involved child; adapting toys and materials for easier use, for example, making crayons or

markers wider for easier grasping by wrapping masking tape around them; and varying lights, sounds, and textures in order to provide important information for children with sensory impairments.

10. Make a point of seating a child with disabilities close to the most socially competent of his peers, particularly a competent but somewhat younger child.

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increasingly frustrated by the care providers' failures to move him along with the group. Sometimes he would join in the imitative play from a distance. He began to pounce on any opportunity when he was not physically constrained to crawl, and then walk, to where the other children were. His movements became faster and more purposeful. Trevor's moment-by-moment goal seemed to be to get close to the other children and do what they were doing. This interest in watching and imitating proved to be a powerful motivating force for him to try activities he'd refused before. Being familiar with sign language made him proficient at finger plays during music time. Trevor's previous interest in letting balls roll away from him and crawling after them gave way to shyly hanging around ball play at the center, and insistently initiating reciprocal ball play at home with his parents.

For Trevor, being able to watch other children provided an opportunity to experience the many ways in which he and they were the same. Being around other children motivated him to try the wide range of activities that could allow him to be part of the group.

In infants' first relationships with adults, they learn to enjoy being with other people. Babies with positive first experiences learn that adults (and people in general) can be caring, loving, and responsive. Thus infants learn to like people. They believe that people (adults and children) are fun and interesting to be with and that they can benefit from being near them.

Toddlers show an interest in other children, as well as adults, and want to be around them. Twenty-two to twenty-four-month-olds, compared to ten to twelve-month-olds, showed significantly higher frequencies of both interactions with peers and contacts with toys. Watching and distant social contact were more common than physical contact. Children from 10 to 24 months do not appear to treat each other like physical objects. Their social responses toward each other are not like those made toward adults (Eckerman, Whatley & Kutz, 1975).

Imitating another's actions is a core behavioral accomplishment during the toddler period. Watching and imitating are seemingly very important ways that toddlers learn from each other. Their ability and interest in imitating increase as toddlers become older (Eckerman, Davis, & Didow, 1989).

What do we know about imitation among toddlers with disabilities in integrated settings? Wittmer (1991) found that in fourteen hours of observation of seven toddlers, the toddlers with a variety of special needs made 117 initiations to other children. Only six percent of these resulted from a teacher's direction to interact with another child. Twenty-three percent of all positive/neutral behaviors included watching another child, while 23 percent of the behaviors included imitating another toddler. Approximately 70 percent of the total interactions of the observed toddlers with special needs with other children were with typical peers, 24 percent were with a mixed group of typical and exceptional peers, and only six percent were with other special needs toddlers alone. It would seem these children enjoyed being with typical peers. Seventy-nine percent of all interactions (as initiators and recipients of interactions from other children) were positive; these included joining in play, comforting, helping, giving, saying "Look at me," conversing, or showing or offering a toy.

Two children with severe motor impairments, however, did not initiate to other children. Another toddler with language delays also did not initiate interactions on his own.

Kevin wandered around the play room, running first to the chalk board and then over to the swing. A teacher, rocking a boat full of children, called to him. "Kevin, do you want a ride?" Kevin glanced at the boat and ran to the other side of the room. The teacher called again as she rocked the boat, "I need some help. Will you help me rock the boat?" Kevin again ran to the other side of the room and from a safe corner watched the teacher rock the boat for several minutes. The teacher gestured for him to come over. Kevin looked longingly at the teacher and boat and walked slowly to the boat and began to help push. The teacher sang, "Row, row, row your boat."

These children needed a caregiver to take a very active role in helping them "get started." Caregivers may need to guess the meaning of the child's signals, help to manipulate the child's hands to sign or play, and actively engage the child in some form of social contact.

Learning the other side of the relationship: How to be prosocial

This morning nothing in the toddler room interested Amber. She stared ahead blankly while fingering a cracker at the snack table. She didn't seem to notice when the other children cleared their things and moved on to play around the room.

Amber has a syndrome that made her head grow large and heavy for her body to carry. Her nose is small and her tongue so large in her mouth that sometimes simply maintaining her breathing and sitting upright require all of her concentration and energy.

Amber's care provider lifted her from the snack table to a quiet spot on the carpet. "Here's your favorite, Amber," the caregiver said directly into Amber's ear as she showed her a shape sorting box. Amber did not respond. "Would you like a record?" the caregiver tried again, "Or maybe this _____" and the caregiver set a small xylophone in front of Amber. The caregiver moved across the room to talk to another child, maintaining her quiet supportive attitude as she moved from child to child.

James, another toddler, scooted in next to Amber facing the xylophone. James picked up one mallet and began to strike the keys carefully and with great pleasure. "Wanta play?" he asked Amber, who was sitting very still, except for snuffly breathing. Amber slowly looked at James, who took her gaze as an affirmative response. James picked up the second mallet, used his chubby fingers to pry open her stiff fists, fitted the mallet against her palm and helped her close her fingers around the stick. "Now you can play, Amber", he said, as he began to help her make her own music.

As they interact in their first relationships, young children "learn the other side of the relationship" and then model the sensitive caring or the not-so-loving responses that they have received. They then use those same interactive strategies with both adults and peers.

The child who is responded to by adults in affectionate, kind, empathetic ways is learning how to be a communicative partner who knows how to take turns, listen, empathize and help. Park & Waters (1989) found that when two children who had experienced affirmative first relationships with their mothers played together, the play was more harmonious, less controlling, more responsive, and happier than when children who had not experienced positive first relationships played together. Howes & Farver's (1987) work shows that toddlers in child care, ranging from 16 to 33 months of age, responded prosocially to peers who showed distress. Ninety-three percent of peer responses to children's cries were prosocial in nature.

Children who have been abused also show that they have learned "the other side of the relationship". In their 1985 study of 10 abused and 10 matched toddlers, ranging in age from one to three years and all from families experiencing stress, Main and George found that toddlers who have been abused will not show concern for a toddler in distress. Rather, the abused toddlers were found to physically attack, show fear, or

Strategies for building on and encouraging children's desire to watch, imitate and be near others

1. Place infants beside each other on the floor, in supported seats, or facing each other in high chairs. Infants like to watch each other.
2. Provide duplicates of toys to encourage parallel play.
3. Offer toys and activities that promote social interaction rather than isolated play. Some favorites among toddlers are a large bin full of ping-pong balls, water, or sand; coloring or painting on a huge sheet of paper that everyone shares; or musical instruments.
4. Find a way to include children with special needs meaningfully in all activities. They need to participate fully with appropriate goals.
5. Care providers should make an effort to have typically developing peers near the child with disabilities during the day. Sometimes we tend to group all the children who need special help together and they have less opportunity to learn from more competent children. If a child with disabilities is not independently mobile, he should be moved with the rest of the children when they move. If the children move from the snack table to free play, a care provider should help the child with disabilities to move with the others, so that he is not always the last to get to a new activity or the last to get a turn.
6. Build on toddlers' inherent desires to imitate others by focusing the attention of the child with disabilities on the behavior of other children. If other toddlers are patting a table, say "pat-pat-pat" as you show the child how to pat his/her hand on the table. Encourage all of the children to play imitative games with sounds and movements.
7. Toddlers like to play beside each other. A child with special needs may need help joining the other children in settings such as a sand box or a wading pool.
8. It may be necessary to use supports and prompts to help some children stay involved in activities with other children. The strategies used to support the child should be as nonintrusive as possible. If a spoken facilitation such as, "Look what you did. You moved it way over here" does the job, it is much better than your standing behind the child guiding his hands in yours.

show anger to the distressed toddler. Three of the abused toddlers alternately attacked and attempted to comfort the crying toddler. This ambivalent approach, alternating between comforting and angry, hurting attacks, probably reflects how the abused toddlers were treated by the important adults in their lives. The nonabused toddlers from stressed families did show concern and sadness, and often attempted to comfort a toddler in distress.

In a more specific illustration of what it means to learn the other side of the relationship, typically developing infants learn about the ways their parents compensate for them in infancy as communication partners. We know that children as young as three will simplify their language with younger children, dolls, and animals. Toddlers may in turn compensate for the limitations of a child with disabilities as a communication partner (with a little encouragement from adults). When typical toddlers in an integrated setting began an interaction with a toddler with special needs, 88 percent of those behaviors could be considered prosocial (comforting with a pat on the head, saying "sorry", turning on the water in the sink, playing ball, giving a turn). These behaviors did not happen frequently, but approximately 50 percent of the behaviors observed were initiated by the typical toddler herself (Wittmer, 1991).

Haniya a toddler with cerebral palsy, crawled with great difficulty, making her way across the sand to the door of the building. Carl, riding by with great speed on his tricycle, came to an abrupt halt, got off his bicycle and leaned down by Haniya. He patted her head gently, and then hopped on his bike and rode off.

Although this action on the part of Carl may seem condescending to some, it demonstrated that Carl seemed to want to comfort Haniya, and did so in the best way he knew how. Patting Haniya on the head had no benefit for himself and thus seems truly a prosocial act.

Caregivers, however, also play a very important role in helping young toddlers learn how to be helpful, caring, and kind

The caregiver positioned Haniya on the countertop, so that Haniya could hold her hands under the faucet. Jonathan appeared out of nowhere to wash his hands before snack. The caregiver said to Jonathan, "Please turn on the faucet for Haniya." Jonathan did. Haniya glanced at him and gave a faint smile. She stuck her hands under the faucet of running water, seeming to enjoy the cool feeling on her hands. Jonathan stuck his hands under the water also and then quickly ran off again. Haniya peered at the place where Jonathan had gone.

Are toddlers with special needs learning the other side of the relationship and behaving in prosocial ways? Four of the seven toddlers observed did not comfort others (Wittmer, 1991). However they did help (2% of positive initiations), they gave objects (7%), showed objects (3%), showed affection (1%), smiled at a peer (13%), and touched gently (3%). They also did a great deal of watching and imitating and "Imitation is the sincerest form of flattery." Only 12 percent of the prosocial actions of the toddlers with special needs were teacher-directed. The few hurtful behaviors of these children involved slapping, yelling at, and scolding other children.

There is evidence that children are capable of initiating positive acts and behaving more prosocially as they mature. Holmberg (1980) found that the frequency of both initial positive acts and "elaborated interchange patterns" increased with age across 12-month to 42-month-old children. Eckerman, Whatley and Kutz (1975), found that toddlers' positive interactions outnumbered negative ones, and positive interactions increased at a faster rate than negatives ones.

Toddlers demonstrate the first steps of social competence through their prosocial behaviors in group settings. Caregivers as well as parents help young toddlers develop the foundations of social competence by helping them (1) gain a sense of competency and self-confidence, (2) learn to like and enjoy others, and (3) learn how to be prosocial through experiencing the positive aspects of "the other side of the relationship."

Strategies for helping children become more prosocial

1. Respond quickly and sensitively to babies' needs so they will feel secure and learn how to treat others gently and kindly.
2. Model treating all children in the ways you want them to treat others. Your example of kindness and appreciation will influence the tone of the interaction among the toddlers in your room.
3. Help toddlers learn cause and effect in social relationships. Teach them how their behaviors affect others. Say "You smiled—that made her happy" or "You hit him—that hurt him" (said with feeling).
4. Offer toys that promote cooperation, such as a heavy wagon with a handle large enough for two children to pull together.
5. Coach peers through approaching the child with disabilities. "Here, Juan, you can ask Michael if he wants this puzzle or that one. Good. Carry them to Michael. Hold them where he can look at them. Ask him 'Which one, Michael?'," etc.
6. Point out every child's prosocial behaviors with admiration to the other children.
7. Encourage problem solving and understanding by using dolls with special needs. Say, "This doll can't see. How can we help her eat?"
8. During free play times, subtly arrange small groups of two to three children to increase cooperative play.
9. Encourage children to help each other. Say, "His nose is running. Get a tissue please," or "Turn on the faucet for Kayla, please."
10. Acknowledge the differences between children, but stress the likenesses among them. "Taylor uses his hands to talk, instead of his mouth. But he wants another cookie just like you!" or "Jane's hands have trouble holding the chalk, but she likes all the pretty colors on her picture, too."
11. It may be necessary to teach a child with severe disabilities how to perform such basic social skills as smiling. This may be done by rewarding the skill (i.e., smiling) when it appears spontaneously or by direct instruction.

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Bibliography

Bronson, WC. 1975. Developments in behavior with age mates during the second year of life. In M Lewis and L Rosenblum, (Eds.) *Friendship and Peer Relations*. New York: John Wiley and Sons.

Bruder, M, Deiner, P, & Sachs, S. 1990. Models of integration through early intervention/child care collaborations. *Zero to Three, X* (3), 14-17.

Eckerman, C, Davis, C & Didow, S. 1989. Toddlers' emerging ways of achieving social coordinations with a peer. *Child Development, 60*, 440-453.

Eckerman, C, Whatley, J, & Kutz, S. 1975. Growth of social play with peers during the second year of life. *Developmental Psychology, 11*, 42-49.

George, C & Main, M. 1979. Social interactions of young abused children: Approach, avoidance, and aggression. *Child Development, 50*. 306-318.

Gilkerson, L, Hilliard III, A, Schrag, E, & Shonkoff, J. 1987. Report accompanying the education of the handicapped act amendments of 1986 and Commenting on P.L. 99-457. Washington, D.C.: National Center for Clinical Infant Programs.

Guralnick, MJ. 1990. Major accomplishments and future directions in early childhood mainstreaming. *Topics in Early Childhood Special Education, 10*(2), 1-17.

Hanline, M & Hanson, M. 1989. Integration considerations for infants and toddlers with multiple disabilities. *JASH, 14* (3), 178-183.

Honig, A & Wittmer, D. 1992. Prosocial development: Caring, helping, and cooperating. A resource guide for parents and professionals. New York: Garland Press.

Howes, C & Farver, J. 1987. Toddlers' responses to the distress of their peers. *Journal of Applied Developmental Psychology, 8*. 441-452.

Jacobson, J & Wille, D. 1986. The influence of attachment pattern on developmental changes in peer interaction from the toddler to the preschool period. *Child Development, 57*, 338-347.

Klein, NK & Sheehan, R. 1987. Staff development: A key issue in meeting the needs of young handicapped children in day care. *Topics in early childhood special education, 7* (1), 13-27.

Main, M & George, C. 1985. Responses of abused and disadvantaged toddlers to distress in agemates: A study in the day care setting. *Developmental Psychology, 21* (3), 407-412.

Minde, K, Perrotta, M, & Hellman, J. 1988. Impact of delayed development in premature infants on mother-infant interaction: A prospective investigation. *The Journal of Pediatrics, 112* 136-142.

Newby, P. 1990. Individualized child care for infants and toddlers. *ACEI Infancy Division Newsletter, 3* (1), 1-3.

Odom, S & McEvoy, M. 1988. Integration of young children with handicaps and normally developing children. In S Odom & M Karnes (Eds.), *Early intervention for infants and young children with handicaps: An empirical base*. (pp. 241-267). Baltimore: Paul H. Brookes.

Park, K & Waters, E. 1989. Security of attachment and preschool friendships. *Child Development, 60*, 1076-1081.

Pawl, J. 1990. Infants in day care: Reflections on experiences, expectations and relationships. *Zero to Three, X* (3), 1-6.

Turnbull, HR & Turnbull, A. 1990. The unfulfilled promise of integration: Does Part H ensure different rights and results than part B of the Education of the Handicapped Act? *Topics in Early Childhood Special Education, 10* (2), 18-32.

Vandell, D & Mueller, E. 1980. Peer play and friendships during the first two years. In Foot, H, Chapman, A & Smith, G (Eds.). *Friendship and Social Relations in Children*. New York: Wiley.

Wasserman, G, Allen, R, & Solomon, C. 1985. At risk toddlers and their mothers: The special case of physical handicap. *Child Development, 56*, 73-83.

Wittmer, D. 1991. Toddlers with special needs as initiators and recipients of prosocial behaviors. University of Colorado, Denver. Junior Faculty Award Report.

Supports for child care programs and providers

10

Attending to the emotional well-being of children, families, and caregivers: Contributions of infant mental health specialists to child care

Editor's note:

The essence of good child care for infants and toddlers lies in the quality of the relationships between and among caregivers, parents and children. It is in the context of these relationships that both the common, basic needs and the unique, individual needs and wishes of very young children are met—or not. It is in the context of these relationships that infants and toddlers continue to develop their expectations about how the world is and how the adults in that world behave. Attachment, intimacy, empathy, separation, autonomy and sense of self and self-worth are major issues in the first three years of life—not only for infants, but for parents and for child care providers as well. Good child care for infants and toddlers builds on adults' awareness and understanding of these issues and their ability, through their relationships with each other and with the children in their care, to encourage their healthy resolution.

Providers, planners, and observers of child care for infants and toddlers have for many years been sensitive to issues of emotional development and well-being in the day care context. As understanding of infant mental health issues has increased, specialists have provided assistance to parents and caregivers around the needs of troubled or difficult individual children. More recently, mental health specialists have explored ways to make day care settings in general more supportive of the emotional well-being of infants, families and caregivers.

The three essays that follow have been adapted from seminar presentations at the December, 1989 National Training Institute of the National Center for Clinical Infant Programs. They describe three distinct but related models for incorporating infant mental health insights and strategies into the practice of day care for very young children. These models include mental health consultation to day care programs; program design and evaluation; and advanced training for day care professionals themselves.

Mental health consultation to day care providers: The San Francisco Daycare Consultants Program

Kadija Johnston, M.S.W.

Mental health consultation, whether it focuses on a particularly difficult child or on an equally distressing but more general program issue, is centered upon and conducted through relationships.

Daycare Consultants is a recently established component of the Infant-Parent Program (UCSF) providing case-centered and programmatic consultation to caregivers serving children birth to 5 years of age. While case-centered consultation is necessary and helpful, the effort is intended to have a positive effect on all the children in any day care program with which we are working.

The essence of good care lies in the quality of relationships between caregivers, parents and children. Our appreciation of the power of relationships comes from our experiences as caregivers in both regular and therapeutic day care settings, as consultants to a variety of agencies, and as infant parent psychotherapists. It is this appreciation that led to our program's conceptualization of what mental health consultation should be.

Mental health consultation, whether it focuses on a particularly difficult child or on an equally distressing but more general program issue, is centered upon and conducted through relationships—those between consultant and consultee, and between adults (parents and caregivers) and children. It is the similarities between these relationships and the parallel processes involved in them that inform our understanding of how consultation proceeds.

Only by forming a positive relationship with a provider can a consultant truly make available her specific expertise, knowledge and understanding of young children. Just as a child's interest in learning about the world depends on how the information is presented, so the caregiver's interest in exploring new developmental and psychological theories depends on the consultant's ability to create a predictable and protective atmosphere, and to recognize, empathize with and respond to a caregiver's particular concerns. As the caregiver begins to feel that her experience is understood, she will develop trust in the consultant and, eventually, in the consultant's knowledge about children and adult-child interaction.

Consultation aims ultimately at improving the overall quality of care provided to children by increasing caregivers' awareness and understanding of the child's experience. But this aim is realized only as the caregiver comes to appreciate and value the genuine importance of her impact on the children in her care. This is no simple process, especially when the caregiver's relationship is not with one child but with a group of young children, each with unique needs and wishes as well as common developmental needs.

Caregivers often seek mental health consultation for the first time when they are especially worried, alarmed or frustrated by the behavior of a particular child. Even though the eventual goal of consultation is

to improve the overall quality of care for all of the children in a particular program, the initial step in the process must be to respond to a caregiver's immediate needs. The consultant strives to learn about the expectations that both the caregiver and child carry into their relationship with one another; to help the caregiver interpret the needs which are being expressed by the child's behavior; and to understand and empathize with the feelings that the child engenders in the caregiver.

Children who are experiencing difficulties, and consequently are difficult to care for, arouse feelings of anxiety, anger and self-blame. As the caregiver begins to feel that the consultant understands and empathizes with these feelings and is not condemning or judgmental, a trusting and mutually respectful relationship can develop. Within this relationship, the consultant's more didactic developmental and mental health information can become useful in shifting the caregiver's perspective about a particular child's difficulties or about broader program issues.

It is important to note that when a particular child is the focus of consultation, we involve the child's parents from the beginning. Information about the child is shared with the consultant only with the parent's knowledge and consent. Observation of the child at the day care setting—with the parent's permission and at the caregiver's convenience—is followed by ongoing consultation to the caregivers and continued contact with the family. The specific ways in which a consultant may prove useful to a particular family are determined by the family's needs and wishes. Initially the consultant may simply help the parents acknowledge and understand that their child is having some difficulties, but the consultant deals with whatever concerns arise—from exploring the effects of the child's past on his present needs, to helping parents with issues of childrearing, to ensuring that parents are engaged with appropriate agencies when longer term help is needed. Her relationship with the child's parents also allows the consultant to put together a picture of the child's background and relationships, in order to help the caregivers better understand the child's current behavior. As the child's behavior becomes more comprehensible, caregivers are better able to respond empathically and with appropriate action.

Two vignettes illustrate our work. In the first, providers who initially request consultation around one troubled child discover that the usefulness of understanding a child's feelings and needs is not limited to a particular case. In the second, program consultation is requested initially and directly.

Cara and her caregivers: Case-centered consultation

The initial step in the process must be to respond to a caregiver's immediate needs.

The director of an infant/toddler day care center and her staff requested case consultation because of their worries about Cara, a frequently withdrawn and unresponsive toddler. Her worrisome behavior had begun several months earlier when, at one year of age, Cara had been moved from the infant to the toddler room.

One of the first things that the consultant discovered was that despite the fact that Cara's mother visited her child regularly during lunch time, day care staff had discussed Cara's situation with parents only infrequently. Now, at the very time that Cara's caregivers and parents needed to help each other the most, they remained unfamiliar to, and increasingly suspicious of, each other.

Talks with Mrs. Brown, Cara's mother, confirmed the consultant's hunch that the child's parents shared the caregivers' concerns. Not only were they upset about Cara, but they were further distressed at not being able to share their worries with day care staff.

With the parents' consent and with mother present for part of the time, the consultant visited the toddler room to observe Cara. She noted the quality of all the interactions in the room—both those

Once the caregivers were aware of themselves in a relationship, they could focus on the infants rather than on particular activities.

involving Cara and her mother and those involving other mothers and toddlers. All the day care staff were kind and warm. They worked diligently at feeding, diapering, and offering a variety of play options. However, these activities of the caregivers seemed, paradoxically, to obstruct interaction among adults and children rather than to encourage it. While Cara was the most withdrawn toddler in the group, none of the ten children seemed able to secure specific engagement with their caregivers in response to their interesting discoveries or through their verbal expressions. They showed little curiosity and spoke or vocalized infrequently. The impression was that as the children failed to be responded to, they came to expect no response, and had begun not to seek any.

Similarly, communication between parents and caregivers seemed almost nonexistent. When they did speak to one another, conversation was strained and stilted. The presence of parents in the room seemed to confuse further what the children's relationships with their caregivers should or might be. No one appeared to understand who was responsible for the children; no one addressed the confusion parents, caregivers and children were clearly experiencing. Parents' arrivals and departures were particularly awkward and silent.

The consultant began meeting with the director and the toddler room staff. Although the consultant's initial questions pertained to Cara, staff began over time to think about their experiences with other children and families in their program. They realized that because of her temperament and previous experience in other relationships, Cara was expressing distress in more discernible ways than the other toddlers. But as discussions with the consultant continued, the caregivers began to recognize the impact of a general lack of relatedness throughout the program on other toddlers, on parents, and on themselves. It was particularly important for caregivers to reexamine their perception that they existed for the children only at those moments when they, the caregivers, chose to relate to them. When they came to see that they were an important part of children's experience *all* of the time in day care, they could begin to appreciate that the children might often feel alone and abandoned.

Now discussion could begin about what the caregivers' relationships with children could be. Their new sense of significance did not mean that caregivers had to, or were able to, become singlemindedly invested in interacting with an infant every minute. Rather, once they were aware of themselves in a relationship, they could focus on the infants rather than on the particular activities of feeding, diapering or presenting objects.

The caregivers also came to think differently about their importance to parents as they recognized the need for all the adults in a child's life to share an understanding of the child's ongoing experience. Rather than simply presenting parents with charts of bowel movements and feeding times, the caregivers began sharing anecdotes that provided parents with a way of participating in their child's experience even though they were separated from one another. As parents were able to reciprocate, the caregiving adults—parents and child care staff—knew both the child and each other better. Rather than feeling either competitive with one another or totally and separately responsible, they could begin to recognize their shared responsibility for the child.

Changes and choices: Program consultation

The following glimpses of the initial sessions of a program consultation illustrate the many levels of intervention and numerous relationships involved in this type of consultation.

The new program director of a very large, subsidized day care center called for consultation. He was concerned about the level of distress, apathy and resignation that seemed pervasive among the staff in one

of the center's classrooms. But new on the job and pressed by multiple demands, he could not offer ideas about why the classroom staff and children were suffering.

An observation and a discussion with Paula, the head teacher, suggested to the consultant that the preponderance of particularly difficult children in this classroom contributed to some degree to everyone's sense of helplessness. But so did recent changes and cutbacks in personnel. Change itself—the way its occurred and it's effect on both caregivers and children—became the focus of several meetings.

In her first meeting with the consultant, Paula expressed a wish to make more changes in her own staff and curriculum. She felt no hope, however, that the classroom aides would support any of her ideas. In exploring with Paula why the aides might lack the enthusiasm and interest which would be needed to make successful changes in the classroom, the consultant realized that the notion of change that was inspired by interest and enthusiasm was foreign not only to her aides but to Paula herself.

Meetings with the classroom staff, all of whom had worked in the center for more than ten years, revealed that change in the center had come to be associated inextricably with loss—loss of staff, loss of pay, loss of vacation time, and, most significantly, loss of control. Change, in their experience, simply meant being acted upon. The consultant reflected on the impact of these experiences. She also recognized that even meeting with her, given the fact that they had not requested the consultation themselves, might seem to the staff like another unwanted change, a burden added to an already overwhelming job.

The opportunity to choose change, rather than succumb to it, ultimately allowed this staff to remember what it was they had once enjoyed about their jobs. They were able to envision ways in which they could improve their program. Not surprisingly, the process of implementing change was more significant than the programmatic change itself. For example, when staff members were able to anticipate and control the changes in routine involved in introducing a morning free play period to the program, they became able to think about the importance of preparing children in advance for the new format. Passing along the control that they had been allowed to take, staff could give children choices about where and with whom they wished to play.

But the new free play period meant that children now needed new kinds of assistance from the staff, who once again questioned their abilities and their relationships with children and each other. An aide, apparently uncomfortable in the unstructured play period, reverted to ritualized preparation of snacks or monitoring of the bathroom, tasks she had previously been relegated to perform. The head teacher was able to convey her irritation to the consultant, but not directly to the aide. The consultant now worked to understand the meaning of the aide's behavior; to acknowledge the head teacher's distress while helping her gain empathy for her staff member; and to help the head teacher understand some of the ways in which her own past experiences made it difficult to express concerns to staff. Within the network of trusting relationships that had been established, difficult feelings could be expressed and new ways of relating to children supported.

Not surprisingly, the process of implementing change was more significant than the programmatic change itself.

Promoting and safeguarding early relationships in child care: The Child Care Dallas Family Day Home system

Sonya Bemporad, M.A., CSW/ACP

We are determined to safeguard the infant's development of a sense of self within meaningful, positive relationships.

Our programmatic response to infant mental health issues in day care should be seen in the context of policy as well as practice. For some babies and their mothers, "good enough" day care supports development; for others it will not. What if day care itself is the or a pathogenic factor in an infant's development? Are we attempting to cure a disease we have created? How do we differentiate among babies' needs? How do we "protect" the ones for whom "good enough" day care does not suffice?

The fact that we develop the best possible program design for infants in day care, or shore up relationships and development with consultation, should not take our energy and attention from the needs of all babies to have a primary, intimate, ongoing relationship with an emotionally invested caregiver for whom this baby has special meaning and importance.

Parental leave provides an opportunity for the primary parent and baby to attach before other caregivers enter the relationship. It is this kind of policy, combined with sound child care programs and practices that we need to foster the healthy development of infants and families.

Child Care Dallas is an eighty-nine-year-old United Way and federally funded day care agency that cares for some one thousand infants, toddlers, and preschoolers daily in a variety of settings and programs. An infant mental health perspective is a central influence upon Child Care Dallas program design, especially in those settings which the Agency manages directly. We are determined to safeguard to the greatest extent possible the infant's development of a sense of self within meaningful, positive relationships. To this end, we have looked for ways to assure: 1) continuity of caregiving, both during the child care day and over time; 2) protection of the primacy of the parental relationship through parental control over and access to the child care setting; a sense of intimacy in the child care experience; and placement of siblings together. A family day home system has seemed to be the best way to assure that the same person relates to the infant and family each day, that the young child is cared for in a small group, and that the entire experience retains an intimate, domestic quality for everyone involved.

Program and social work staff at Child Care Dallas have developed several strategies to make this vision work as an ongoing system to assure that child care settings foster the healthy development of infants and families.

The ongoing relationship between the agency and the family day home mother begins with a social study of each family day home. The strengths and weaknesses

of the home are evaluated with a view to understanding what kinds of infants at what developmental stages this particular home could nurture well. The worker explores the day care mother's motivation for this kind of work, her feelings about young children, her own in-home relationships, her thoughts about dealing with isolation and loneliness, and her attitudes about childrearing. She is invited to describe her own experiences of loss and separation, and think about the kinds of behaviors in infants and toddlers that she finds appealing or unappealing. The prospective family day home mother is encouraged to express and reflect on her feelings about working parents who place their infants in child care and, given that Child Care Dallas serves Protective Services clients, about parents who might neglect or abuse their young children. It is our experience that providers' feelings of competitiveness or differences in values between provider and parent can be addressed and resolved—but only if opportunities are offered for them to be recognized and expressed. The social worker is especially sensitive to the caregiver's ability to understand that her own history has something to do with the quality of the care she will be able to give infants and families.

The placement process with the family is similarly attentive to emotional issues. A child and family history is taken which includes experiences of pregnancy and childbirth; current developmental information; previous separations of parents and child; previous child care experience; and information about how the infant communicates distress and can be comforted. Parents are asked to describe what they particularly value in their child. They are invited to discuss their expectations about their relationship with the day home mother. With some 50 homes in the Child Care Dallas system, families do have choices about placement. They are encouraged to visit several homes to see which seems most consonant with their own needs and feelings.

The agency works with parents to take a careful look at the beginning of the child care arrangement, with visits planned to the family day home before care begins. Discussion is encouraged about the distress both infant and parents feel as separation occurs. When, as sometimes happens, infants and toddlers do not show developmentally appropriate distress in the unfamiliar setting, we are concerned. We work with the family day home mother to gain a better understanding of the quality of the infant's relationships and to think about ways of strengthening the child's important relationships, both with the parents and with the family day home mother.

A detailed annual program audit provides a way to look at the experiences of infants, parents and caregivers over time. We meet with each family day home mother to review the physical environment, safety, health practices, play opportunities, awareness of children's development, opportunities for communication of feelings, how parents are involved in encouraging the child's development, and relationships with parents. We then use the results of that review as a guide for the ongoing work with the child development specialist, social worker, and day home mother.

A detailed annual program audit provides a way to look at the experiences of infants, parents and caregivers over time.

Assessment of infants and toddlers in care several times a year allows the agency to know where children are developmentally, and to plan genuinely individualized programs for each child. Our assessments have been based on observations of the child across various developmental domains. We are exploring the use of Gilbert Foley's Attachment/Separation/Individuation Index to focus our assessments on the child's achievement of self and object constancy, those developmental achievements most at risk in substitute care. When our assessment observations have been made and summarized, we meet with parents to share our impressions and to get their perspective on the child's development.

If worries about an infant or toddler's development are expressed by the parent,

the day home mother, the child development specialist who visits the day homes monthly, or the social worker who is in contact with the parents, a staffing is scheduled to share information and think through strategies. Just as we value the overall primacy of the parental relationship, so we try to protect the primacy of the day home provider/parent relationship. Rather than adding another professional to the equation, we try to help the day home mother work directly with the parents to share and resolve concerns about a child's development. Of course, when specialized help outside our system is needed, we will work to arrange this.

Our system is an evolving one. We have seen important positive changes and are continually looking for new ways to understand and protect the emotional well-being of infants and toddlers in child care.

Reducing turnover among family day home mothers as well as professional staff has been a prime goal, a prerequisite for creating a child care system where continuing relationships can be relied upon. As we work with day home providers, we have encouraged more autonomous functioning among them, supported professional accreditation, and offered increased pay to providers who increase their professional skills, provide consultation to other day home mothers, or conduct training workshops. The turnover rate among family day home mothers has decreased from 40 percent annually three years ago to less than 20 percent this year. Similarly, by making professional staff in the central agency accountable for their own specialized work—child development or social work—rather than generally responsible for management of the family day home system, we have increased satisfaction and reduced turnover among these employees as well.

We continue to be concerned about the central aspects of emotional development that may be at risk when infants and toddlers are in child care. Including the Attachment/Separation/Individuation Index as part of our periodic assessment of children will give us a more sophisticated understanding of how they are faring in these areas. While our outcome research to date has looked at how well children who have been in our day care programs function in school, we look forward to developing outcome measures that will reflect children's level of success at the central tasks of the first three years of life—at the quality and nature of their human relationships.

An infant mental health training model for day care professionals: The C.M. Hincks Institute National Day Care Training Project

Elisabeth Muir, M.N.Z.A.C.P. and Elizabeth Tuters, M.S.W., C.S.W./M.C.A.P.P.C.

Recent infant observational and attachment research emphasizes the importance of the earliest infant-caregiver relationships for the development of optimal human functioning. The quality of a child's various attachment relationships seems to have more to do with that child's development than whether or not the young child's was cared for solely by parents or in a day care setting as well (Morris, 1989, personal communication). Therefore, anyone involved with the early caretaking of children needs to understand the importance of a hierarchy of attachment relationships to the child's emotional development, as well as the effects of an equivalent hierarchy of separation experiences. It is also important to understand the mutual impact of relationships that cross generations and involve many parts of the young child's world—the family, day care providers, day care institutions, and societal and political systems (Bretherton, 1985; Emde, 1988; Fraiberg, 1980; Main and Goldwyn, 1984; Stern, 1985).

To achieve such understanding, however, involves—for most of us—learning to see, know and feel what we have previously avoided seeing, knowing and feeling about infants' experiences in relationships (Bowlby, 1979; Tuters, 1988; Tuters et al., 1989). Our avoidance may stem from defenses of thought established in the course of our own efforts, as infants, to cope with failures in attachment relationships. Reflected in the society at large, such avoidance may take the shape of training for early childhood professionals that specifically excludes attention to emotional development, or of social policies that dismiss the relationship needs of infants and young children.

Precisely because day care facilities in Canada are relatively closed to the influence of children's mental health professionals, we at the C.M. Hincks Institute for Training, Research and Resource in Toronto decided to train day care staff themselves as mental health consultants and involved the day care system in planning the training program.

In a federally funded pilot project, the Clinical Infant Program of the C.M. Hincks Institute is training three day care fellows per year, selected from senior day care providers who are interested in expanding their role and the quality of day care in the community. Fellows gain expertise in mental health consultation to day care while sharing a common core curriculum with other mental health professionals in training at the Institute.

As we planned the training model, we knew that the day care fellows would come to us well-trained in behavioral, physical,

cognitive and social development. We wanted our curriculum to include knowledge of psychoanalytic concepts, with an emphasis on individual development over time; knowledge of attachment issues; knowledge of family relational systems; and knowledge of consultation and system sensitivity. We knew that our greatest challenge would be designing training that would be acceptable to, and congruent with, the requirements of day care while, at the same time, helping the day care fellows come to see, know and feel what they had previously been avoiding seeing, knowing and feeling.

The fulcrum of the learning experience of our day care fellows is observation—of infants, of small children, and of assessment and treatment.

The fulcrum of the learning experience of our day care fellows is observation—of infants, of small children, and of assessment and treatment. Structured observation, an accepted part of the training programs for child psychotherapists in many countries, including Canada, is an emotional learning experience. Trainees experience the impact on themselves of observing the developing infant, through understanding the feelings aroused in themselves. For day care provider trainees this means becoming able to see what in the past they have been unable to recognize: that is, the pain and distress of an infant or small child and his parents separated from each other; the effect of this experience on the developing child, on the parents, and on the day care providers; and how they all cope.

Infant Observation involves the student in weekly in-home observations of the developing infant in the family, from birth over a period of one to two years. Observations last from 45 minutes to an hour, with the observer behaving as naturally as possible but interacting minimally with the infant and family. Note-taking is discouraged; narrative descriptions of the observation are written from memory and discussed in weekly seminar groups. The observations that have been described, and feelings that have been stirred up, are shared with other group members and worked through in discussions. The Small Child and Clinical observation seminars follow a similar format.

Our training program for three fellows (a masters level teacher of early childhood education at a community college; a masters level day care supervisor; and a doctoral level consultant to infant day care programs) has been underway since September, 1989. Vignettes from the observation seminars exemplify the trainees' learning experiences, and so far serve to validate our expectation of the powerful impact on the self of learning through observation.

A vignette from the Infant Observation Seminar

As she described interactions between the mother and the older toddler sibling of the target infant, the trainee herself expressed concern that although she was meant to be observing the infant in the family, she was bringing to the seminar observations only of the interactions between the mother and the toddler. She said, however, that it was not possible to observe a feeding or sleeping baby. Seminar members acknowledged the difficulties of observing without impinging on the mother's or infant's space, but described their own observations of feeding or sleeping infants. A question was raised concerning how much the mother being observed was able to become preoccupied with her infant while she felt so compelled to attend to her older child's needs. It was as if, at those times, the infant did not exist.

The observer became painfully aware that she, like the mother, but for her own personal reasons, had not been able to "see" the infant. The seminar group had helped her discover something about herself and her experience of infants which she had hitherto avoided knowing.

In this same seminar session, another trainee became aware that she too was avoiding self-knowledge. In her own observation, she visited a mother who, depressed and discontent with her third baby, indicated in conversation that she felt she could not meet the needs of her infant because her own needs were not being met. The observer described finding herself not observing the baby, but rather engaging in conversation

with the mother about knitting. She realized that she had been pulled into this mother's world, colluding with the avoidance of her infant's needs.

A vignette from the consultation application seminar

The day care fellow reported that the day care teacher of the small child being observed by the trainee asked her how long and for what purpose the trainee would be observing the child, indicating that she felt it was a waste of time. The teacher also inquired about the in-home observations this trainee had made of this child. The trainee carefully explained the purpose and duration of the observation and clarified boundaries with respect to confidentiality. The following week, the same teacher repeated the same questions. She added that she too was planning to further herself; she did not intend to remain a day care teacher forever.

The trainee could recognize issues of confidentiality and competition and had begun to understand the existence of many levels of communication and the power of personal issues to influence behavior. As she thought about the impact of the teacher's communication on her, she was left feeling lazy and advantaged, in comparison with the relatively deprived, hardworking day care provider. Her clarification about limits on the sharing of observational information increased her sense of being perceived as a person who "had it all" but was withholding what she had (desired information) from the needy teacher.

Whenever the trainee offered some thoughts about the children's behavior, this day care teacher was quick to minimize her contributions. When asked by the trainee for her own thoughts about any behavior or interaction, the teacher would make a brief, dismissing comment, indicating to the trainee the teacher's reluctance or resistance to attempting any understanding beyond a superficial level of the meaning of a child's behavior. The day care fellow was left feeling that she could not communicate clearly—that her own behavior (as someone who believed that observation and understanding a small child's emotional experience were important) could not be understood by this teacher. This would seem to parallel the child's situation.

We believe that training based on observation helps trainees fully understand the impact on themselves of the experience of day care and all of its vicissitudes. Our training helps them understand the experiences of infants, children, families and day care providers. They come to understand how much the source of a child's distress lies within the family system, how much in the day care system, how the interrelationship of day care and family systems impinge upon a child's emotional experience, and how intergenerational repetitions can become intersystemic re-enactments. To struggle with what needs to be done in the earliest years of life is to make possible different outcomes for infants and small children, for families, and for day care providers.

References

Bowlby, J. 1979. Knowing What You Are Not Supposed to Know and Feeling What You Are Not Supposed to Feel. *Canadian Journal of Psychiatry*. V 24, pages 403-408.

Bretherton, I. 1985. Attachment Theory: Retrospect and prospect. In, Bretherton and Waters (Eds.) *Growing Points in Attachment Theory and Research*. Monographs of the Society for Research in Child Development. V 50 (1-2, Serial No. 209), 3-35.

Main, M and Goldwyn, R. 1984. Predicting rejection of her infant from mother's representation of her own experience: Implications for the abuse-abusing intergenerational cycle. *Child Abuse and Neglect*. V 8, 203-217.

Morris, A. 1989. Personal communications.

Stern, D. 1985. *The Interpersonal World of the Infant*. New York: Basic Books.

Tuters, E. 1988. The relevance of infant observation to clinical training and practice: An interpretation, *Infant Mental Health Journal*. V 9 No. 1, Spring.

Tuters, E. Muir, E. Huntley, M and Rustin, M. 1989. Workshop presentation on infant observation, 4th Congress World Association of Infant Psychiatry and Allied Disciplines, Lugano, Switerzland.

11

Whole Babies, Parents and Pieces of Funds: Creating Comprehensive Programs for Infants and Toddlers

by Peggy Daly Pizzo

Every day, providers of early childhood services to infants and toddlers deal with the needs of the whole baby with pieces of funds. Very few whole funding streams are organized so that providers of early childhood services can use one funding stream to serve the whole baby in a family-centered way.

But there are many pieces of federal funding available to support states, local governments and community-based programs striving to provide high quality, comprehensive early childhood services for infants and toddlers. At last count, the General Accounting Office (GAO) enumerated 46 federal programs which provide funds for child care or related services—and the GAO list did not include Medicaid, a funding source which we explore in this article! (General Accounting Office, 1989).

"Piecing together" the funds

To "piece" together the needed funds, early childhood services must learn and use the technical jargon associated with each particular funding stream. An early childhood program which helps low-income families obtain health, educational and social services is, in Medicaid parlance, providing case management services and may be eligible for Medicaid reimbursement for doing so. This same program may also provide developmentally appropriate care that is carefully tailored to all the needs of each baby, including those with developmental delay. In the parlance of early intervention services, this may be a least restrictive environment or a more facilitating environment for infants with special needs. Thus this child care program may be eligible for some reimbursement as an early intervention service under Public Law 99-457.

But in each case, the early childhood services provider must first analyze whether the services they are currently providing or wish to provide are "a good fit" both with the needs of child and family and with the services reimbursable under a particular funding stream. And then the provider must use the technical language of that funding stream, not the language of the early childhood services field, to describe the activities.

By doing so, however, practitioners, administrators and advocates of comprehensive services to disadvantaged children may be able to open up multiple new layers of funds needed to help pay for the caregivers, specialists, health, nutrition, social and educational services and equipment that "whole baby" programs need.

Purpose of this article

This article will inform leaders in the early childhood field about the value of the whole

baby approach to child care. It will also describe the diverse "pieces" of funds which can be blended together by child care programs (or in some cases, by child care resource and referral agencies) to facilitate the care and education of "whole babies" instead of fragments of the needs of those babies.

The "whole baby" approach to child care

The whole baby approach to child care is one that sees the infant as a human being whose physical, cognitive, emotional and social needs cannot be dealt with as separate domains of development. Multiple and interrelated strands of development combine in the infant and toddler in ways that "blur the lines" between these developmental domains more deeply than is ever experienced again in the lifespan.

Early childhood educators and specialists in infant and child development face the challenge of how to respond to this unique characteristic of infancy with early childhood services that are comprehensive. This means services that do not segregate intellectual stimulation from immunization or promotion of prosocial behavior from protection against accidental injury. It means, for example, services which concentrate on skilled and sensitive nurturing of a somewhat unresponsive baby while also concentrating on correcting the anemia which is making the baby listless.

The family-centered approach to child care

Struggling to meet the needs of the whole baby is one of two central challenges in early childhood services for infants and toddlers. The other challenge is the delivery of the service in a family-centered rather than a provider-centered or even only a child-centered way.

The family-centered approach essentially sees the family as the constant in the child's life, around which the service systems must revolve. It is distinct from the provider or service-system centered approach which sees the services as the center around which the child and family must revolve. It is also distinct from the child-centered approach which may take a profound interest in optimizing the development of the child but very little interest in the developmental challenges and changes, feelings, convictions and level of satisfaction with the services that the parent experiences. (ACCH, 1987; Edge and Pizzo, eds., 1988; Woll and Pizzo, eds., 1988.)

A family-centered approach sees the parents of children as usually the most important persons in a child's life. Services are then structured not just to care for the child in the day-to-day absence of the parent(s). Family-centered early childhood services strive to motivate and empower the parents to improve the skills they need to be effective and confident nurturers and educators of their own children (if improvement of those skills is needed). In addition, family-centered services strive to motivate and empower parents to be effective advocates for their children's educational, health, nutritional and social needs (if improvement of advocacy skills is needed).

Five sources of federal funds and the whole baby family-centered approach to child care

With the exception of funds for comprehensive services like the Head Start program and the Comprehensive Child Development Centers (a demonstration program), almost all other federal funds focus on one or at most two objectives related to the child's well-being. Almost none make funds available to foster parent development as well as child development.

However, there are at least five sources of federal funds which can be brought into early childhood and child care programs seeking to become more comprehensive (or into resource and referral agencies which support the development of comprehensive early childhood programs in their communities). These funding sources are described in summary form below.

I. Federal funds for child care under the Family Support Act of 1988

Open-ended federal funds are available for child care for every child eligible for Aid to Families with Dependent Children (AFDC), whose family meets the conditions set forth in the Family Support Act (FSA) of 1988. This new law modifies Title IV-A of the Social Security Act.

Eligibility for FSA funds

These child care funds are available as part of a broader program, whose purpose is to provide incentive and support to AFDC families who participate in employment or training. The part of the FSA which most directly affects infants and toddlers is the requirement that parents between the ages of 16 and 20 who have not yet finished high school participate in full-time educational activities, regardless of the age of their children.

The new law also requires parents of children aged three and up to participate in employment and training as a condition for participation in Aid to Families with Dependent Children. States may impose the identical requirement on AFDC families with children aged 1 to 3, but are not required by federal law to do so. Finally, parents of children of any age may access this federal source of support for child care if they volunteer to participate in employment or training.

These Title IV-A or Family Support Act (FSA) funds can be given to either eligible child care providers or to eligible parents, who then are expected to pay the providers. Unlike Title XX (see below), there is no cap on Title IV-A funds appropriated every year. Thus, the federal government can provide, on an open-ended basis, federal matching funds for every eligible child who participates in child care that meets the requirements of state and federal law.

However, like Title XX, these funds will typically be per-child reimbursements for day to day child care services. A limited amount of funds will probably also be made available in each state for resource and referral services designed to assist the parent in locating child care. Reimbursements cannot exceed the market rate in each locality.

FSA funds can be used to provide a wrap-around service to early intervention, family resource and support or Head Start services which are currently part-day. In a wrap-around, these funds are used to lengthen the day or otherwise lengthen the time that the services are available so that the AFDC parents can fulfill the requirements of the Family Support Act.

II. Federal funds for child care under Social Services Block Grant (SSBG) or Title XX

Funding for child care is also authorized under Title XX of the Social Security Act. Title XX is the social services funding stream. Each year a cap on funds for Title XX is appropriated. Within that federal limit, then, states may draw down federal funds to help them provide social services for any family who is currently eligible under both federal and state policy. Usually these are families with very low incomes. One of the social services which the state may elect to fund is child care. (Each state decides how much money it will spend on each of the social services which are eligible for federal matching funds.)

Child care providers typically participate in Title XX by negotiating a purchase of service contract with the state administering agency, by which the state purchases child care "slots" from the provider for a defined number of children eligible for Title XX. Purchase of service funds are usually provided as a reimbursement to the child care provider for a defined amount of time that the child or children have spent in the child care program. Typically, no funds are provided for resource development, that is to create new child care programs.

III. Federal funds related to child care and comprehensive preventive health care (including family support services) under Medicaid

Child care services are typically required by state law to prohibit admittance to the program to any child who has not met age-appropriate immunizations. (There are exceptions in family day care.) In addition, there are often state requirements that children have physical examinations or health assessments in order to safely participate in child care. These are usually considered necessary safeguards to a child's health when being cared for in groups.

However, for low income families in particular, both child care providers and parents are often deeply frustrated by the difficulties parents experience in obtaining these basic health services either prior to entry into child care or throughout the course of the child's participation in child care.

In some states, child care programs, family resource and support programs, Head Start programs and child care resource and referral services which serve Medicaid-eligible families can now apply for and receive Medicaid funds to assist families in gaining access to needed medical, social, education and other services.

In Medicaid terminology, the service of assisting families in this way is called case management services. This is an optional Medicaid service and must be specifically included by the state in its Medicaid plan before case management services can be funded.

New eligibility for Medicaid

Medicaid is authorized under Title XIX of the Social Security Act. It provides open-ended federal matching funds for those eligible services provided to eligible individuals. Historically, the children eligible for Medicaid were typically (although not always) of such low incomes that they participated in the state's Aid to Families with Dependent Children program. Now children of the working poor—the population of children served by child care programs for economically disadvantaged children—are increasingly eligible for Medicaid and, at state option, for case management services.

As of April 1, 1990, states must include in Medicaid all pregnant women, infants and children up to age six whose families currently earn less than 133% of the federal poverty line. All of these families are eligible for the full range of preventive health care, for medical treatment and for case management services, if the state has chosen to adopt case management services as one of its options. (Note that this new mandate may make the children of many Head Start and child care providers eligible for Medicaid as well.)

Medicaid and case management services

Early childhood service programs or child care resource and referral agencies which either have developed or have the potential to develop good working relationships with the parents of low income infants and toddlers are well-situated to provide case management. Good case management requires a long-term commitment to the family and to assisting the family to secure the services that the children and other members of the family need. It also requires a commitment to helping the parent find a "medical home" for the child—a good ongoing source of medical care which can both prevent and treat health problems. Finally, good case management depends on persistence in exchanging and coordinating information among parent, medical home, child care provider and, at times, other health and social service providers.

To become eligible to be reimbursed for case management services, providers of child care, family resource and support, early intervention, Head Start or child care resource and referral services need to take the following steps:

- identify whether at least some of the population served by their program is or will be eligible for Medicaid and whether they need case management services;

- decide what the elements of the case management services to be provided the families will include;
- ascertain whether the state has yet adopted this option in its State Plan;
- discern who is designated by the State Plan as eligible to be reimbursed as a case manager;
- apply for a Medicaid provider number and discuss methods of reimbursement with the state Medicaid agency.

Medicaid and transportation

Child care programs or resource and referral agencies which assist Medicaid-eligible families in gaining access to needed medical services by providing transportation to doctor visits, dental appointments and other medical providers can be reimbursed for this service under Medicaid.

Many child care providers and perhaps even resource and referral providers use vans to transport children and caregivers for such child-care related activities as field trips. During the significant periods of non-use, providers can use vans to transport children and parents to health services. This is a natural adjunct of case management services and Medicaid can pay for all or part of the operating costs (including insurance) of the vehicles.

Medicaid and developmental assessment and health education

Finally, under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of Medicaid, qualified child care programs may also provide developmental assessments and health education for Medicaid-eligible children and be reimbursed by Medicaid for doing so. State law may limit the licensure of individuals qualified to either perform developmental assessments or provide health education to individuals with certain types of degrees. However, child care programs can enter into contractual relationships with qualified individuals (e.g., licensed psychologist) and apply to become an EPSDT provider.

As with case management services, good screening and assessment requires the exchange of information and coordination with a "medical home" for each child. Collaboration with parents is also essential both to obtain input relevant to the assessment and to encourage and support parents in obtaining follow-up remediation of problems detected by the assessment.

IV. Federal funds for child care programs providing nutritious meals and snacks under the Child Care Food Program

Infants and toddlers undergo such rapid physical and mental development that their need for food with appropriate caloric and nutritional content is acute. In addition, mealtimes for infants and toddlers are essential moments in the development of a baby's emotional health and capacity for social interaction. Therefore staff need to have unhurried feeding times with babies and toddlers.

The costs of purchasing, preparing and serving nutritious food to infants and toddlers can be offset by funds from the Child Care Food Program. Authorized under the National School Lunch and Child Nutrition Act, this program is administered at the federal level by the U.S. Department of Agriculture. At the state level, however, it is administered by the Department of Education, the Department of Human Resources (or Social Services) or the Department of Health.

All children in nonprofit child care centers and sponsored family day care homes are eligible for some type of reimbursement. However, in centers, children in the higher end of the income ranges qualify for only a slight reimbursement, while children in the lower income ranges qualify for a more substantial reimbursement. For-profit centers are eligible for participation in CCFP if their total child population is comprised of at least 25% low-income children,

currently defined as children participating in Title XX. (Recent legislation authorized a small pilot project to broaden this definition.)

The steps which providers of early childhood services must take to apply for reimbursement differ for centers and for home-based programs. Qualifying centers can apply directly to the administering state agency for reimbursement. Family day care homes must work through a nonprofit sponsoring agency, often a center or a resource and referral agency. Since the red tape of applying for reimbursement can be cumbersome to some center providers, some centers are choosing to apply in ways similar to family day care homes, i.e., through an agency that takes responsibility for the paperwork.

V. Federal funds for child care services which provide early intervention services

Family day care homes, child care centers and Head Start programs for infants and toddlers are increasingly asked to enroll infants and toddlers with a variety of special health care needs, developmental delays or atypical patterns of development. This increasing demand is in part due to state efforts to locate children eligible for early intervention services. The demand also reflects parents' need for infant and toddler services which will help them participate in the labor force. Rising medical and other expenses associated with the upbringing of children with special needs propel even more of their parents into the work force—and into the search for child care.

Early intervention services for children under three have been defined in federal law as services "designed to meet a handicapped infant's or toddler's developmental needs in any one or more of the following areas: physical development, cognitive development, language and speech development, psychosocial development or self-help skills." (Education of the Handicapped Act Amendments of 1986.)

Part H of P.L. 99-457, the Education of the Handicapped Act Amendments of 1986, encourages states to identify and provide early intervention services to infants and toddlers who are developmentally delayed or have a physical or mental condition likely to result in developmental delay. (States may also serve infants and toddlers who are "at risk of having substantial developmental delays if services are not provided.") Part H monies are for the planning of services or the expansion of services. States are encouraged to coordinate multiple funding streams; for example, they may use Medicaid to help finance the costs of identifying Medicaid-eligible children through comprehensive health and developmental assessments.

Central to the philosophy and implementation of Part H of P.L. 99-457 is the development of an Individualized Family Service Plan, based on a multidisciplinary assessment of the child and, with the concurrence of the family, a statement of the family's strengths and needs related to enhancing the development of the child. To the extent appropriate, early intervention services must be provided in the types of settings in which infants and toddlers without handicaps participate.

Early childhood programs that wish to become case managers for the infant and toddlers eligible for P.L. 99-457 services may be able to contract with the state to do so. Similarly, those programs that are qualified to provide part of the required multidisciplinary developmental assessment may be able to contract with the state to do so.

It is not clear yet how many states will contract with early childhood programs to provide early intervention services in child care settings. States may be reluctant to use the limited funds appropriated for Part H of P.L. 99-457 to fund the entire costs of an all-day, all-year early childhood program. But they may find it more cost-effective to fund part of the costs of an existing community child care program, and to supply the program with appropriate specialized

services and equipment, than to finance start-up costs for new early intervention services. Child care providers interested in providing early intervention services should contact the lead agency for Part H of P.L. 99-457 in their state and discuss this with agency representatives. They should also try to identify state and local parent advocacy organizations concerned with special needs and make their interest in serving infants and toddlers with special needs known to these organizations. Child care resource and referral agencies can help early childhood program providers connect with the lead agency and with parent advocates for children with special needs—as they can also help parents of infants and toddlers with special needs become aware of their options under P.L. 99-457.

Outlook for the future

The amount of federal financial support for early childhood services is likely to expand substantially over the next few years. Congress will enact child care legislation. Congress will also expand the funds for Head Start. Eligibility for Medicaid and funds for the Child Care Food Program and for P.L. 99-457 may also expand. But the necessity of piecing together funds in order to serve the whole baby and to empower parents will not fade away.

One of the most compelling needs of the 1990s in the field of early childhood services for infants and toddlers is the investment of more funds in all the categories of support mentioned above. But an equally compelling need is the exchange of information, throughout the entire early childhood services delivery system, of creative and workable ways to piece together funding streams. Parents can't be in two different service sites at once. Families don't do well when parents constantly feel torn in two. Furthermore, babies can be damaged by narrowly focused services which ignore, for example, their health needs in order to be exclusively devoted to their cognitive or emotional needs (or vice versa). And once "broken," babies don't get "pieced back together" easily. It's better to piece the funds, provide the support to parents and procure the support we need to help nurture the babies. That's the challenge that faces us now and will continue to face us throughout the coming decade.

References

Association for the Care of Children's Health (ACCH). *Family-Centered Care for Children With Special Health Care Needs.* (Washington, D.C., ACCH, 1987.)

Edgr, Elsie and Pizzo, Peggy, eds. *Four Critical Junctures: Support for Parents of Children With Special Needs.* (Washington, D.C., National Center for Clinical Infant Programs, 1988.)

General Accounting Office. *Child Care: Government Funding Sources, Coordination and Service Availability.* (Washington, D.C., U.S. General Accounting Office, 1989.)

Woll, Jose and Pizzo, Peggy, eds. *The Open Door: Parent Participation in State Policymaking About Children With Special Health Needs.* (Washington, D.C., National Center for Clinical Infant Programs, 1988.)

12

The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddlers and Caregivers

Louis Torelli, M.S.

The physical environment in a group care setting affects children, caregivers, and their interaction. A well-designed environment is, of course, safe for infants and toddlers, but it also supports their emotional well being, stimulates their senses and challenges their motor skills. A well designed group care environment promotes children's individual and social development. It is comfortable and aesthetically attractive to both children and their caregivers.

A developmental environment is designed specifically to promote learning that is both age appropriate and child-directed. The setting, layout and equipment all give infants many opportunities to challenge themselves through seeing, touching, feeling and moving. In surroundings that are safe to explore freely, infants learn to map their environment cognitively, to manipulate it, and to master it.

In group care classrooms without a developmental design, one generally observes young children spending a significant amount of time in either aimless wandering or teacher-directed activities. Because making friends is a social skill that depends on experience as well as age, a group care environment that is teacher-directed can deprive infants and toddlers of opportunities to enjoy positive interaction with their peers. Consider a toddler classroom where the teacher takes out baskets of *Duplos*, brings them to the middle of the room, and sits on the floor surrounded by ten toddlers—all shoulder to shoulder. After only a minute or so, one child grabs another's Duplos. While the teacher encourages this pair to "be gentle," the same battle is beginning between two other children. Then a toddler who has been racing around the classroom suddenly runs to the middle of the room and kicks the tower of another child who has been deeply involved in play.

In contrast, a developmentally designed environment offers infants and toddlers choices of activities and opportunities to break away from the larger group. A multi-level design, for example, varies the floor height with appropriately scaled platforms, lofts, "nests" and canopies. These mini learning environments set up a landscape for safe exploration in which infants can handle a toy, look at a book, stack blocks, crawl up steps, or simply watch the adults and other children from a cozy semi-enclosed "private space."

For toddlers, a developmental design would also include an area for manipulative play with *Duplos*, shape sorters, pop beads, and the like. Such an area would be enclosed by shelves, low walls, or carpeted platforms. Because this would be one of several activity areas available, toddlers could choose themselves when they wanted to engage in this kind of experience and for how long.

Mini learning areas encourage privacy and small-group interaction rather than wandering and herding. In smaller groups, young children can be intensely involved with each other. In an environment that encourages focused play in small groups, relationships among children are less aggressive and more supportive.

After her classroom was redesigned according to developmental concepts, a toddler teacher summarized the differences for children and for herself:

"You can feel the difference when you walk in the room. It's so much more comfortable! Instead of moving around aimlessly, the kids are much more focused on activities. Now they can be active in the classroom without getting into each other's space. Instead of climbing on furniture, they have a place to climb.

Having all this storage makes me a much more organized teacher. In a way I really feel spoiled. But then I think, the kids deserve this, and I deserve this.

It makes me feel so happy."

Let us consider some specific elements of a well-designed group care environment for infants and toddlers.

Layout

Create mini-learning environments by placing multi-level activity areas around the periphery of the classroom. This leaves the middle of the room open for traffic lanes and "stage set" activities such as music and movement experiences. The open central section itself can be varied by using portable equipment such as carpeted risers and bolsters.

Motor challenge

Because motor activity is critical to the overall development of infants and toddlers, the physical environment must provide safe and appropriate motor challenges. A developmentally designed environment supports ease of movement, which then encourages active exploration.

Contrast an environment that encourages climbing, crawling, running and jumping with one that does not. The need to move still exists, but the environment does not support this need. When the setting lacks appropriate equipment, the ten-month-old still moves, but she uses the high chair to pull up to standing and then is redirected because this is not safe. The eighteen-month-old attempts to use the toy and book shelf as a climbing apparatus, but he too is redirected. The two year-old who continually gets up on the table to jump off is redirected as well. The message to these children is: "Self-initiated exploration is not acceptable."

But an environment designed to meet infant and toddler needs supports and encourages active exploration. The children get the message that it is fine to explore and take risks here. Their motor exploration leads to motor competence, which then contributes to emotional well-being.

The role of equipment

Appropriate equipment is essential to meet the motor needs of infants and toddlers in group care. Equipment also affects peer relationships significantly. For example, equipment that may be ideal for individual development may be a burden in a group care environment. And since the field of group infant care is in its own infancy, choices of commercially available equipment are still limited.

Consider the infant ladder-slide found in many child care centers. Older infants and toddlers love to use it, but only one child at a time can play on it. In order for children to use this slide safely, the caregiver must police it, having children wait their turns and redirecting those who have difficulty doing so.

If the equipment were designed to allow more than one child to use it simultaneously, the situation would no longer be stressful for either children or caregiver. Toddlers could be more actively involved in motor exploration, and they would also have an opportunity for positive peer interaction. Instead of controlling and redirecting, the caregiver could be observing, learning more about the infants in her care.

Flexibility for mixed age groups

Mixed age groups present a particular challenge. The environment must support the motor interests of older infants and toddlers while providing safe, relaxed care for young infants.

Shelving, low walls, large pillows, mats, platforms and portable risers can all be used to separate different activities and thus respond flexibly to the diverse needs and interests of a mixed age group. When the whole group is in the room, the caregiver can enclose a corner with a few portable risers. Younger infants will be safe in this protected space with a caregiver, while the older infants and toddlers move freely around the classroom. When half the group is outdoors or several infants are napping, the caregiver can redesign the space to allow for more open play and movement.

Using storage for flexibility

Every activity area in the classroom—for eating, manipulative, art, books, blocks, etc.—should have its own storage space. To reserve as much space as possible for children's use, locate storage space on the walls, at a height of 48 inches or more.

Infant/toddler caregivers inevitably spend much of their time changing diapers. Well-designed storage in diaper changing areas can leave the caregiver available to engage in responsive interaction with the child during diaper changing.

Mental health

A developmentally appropriate space is designed to be emotionally supportive for both children and adults. The setting encourages relaxation. It invites one to spend time.

Track lighting, carpeting, pillows, textured wall hangings, plants and animals can all contribute to a comfortable environment. Photographs of children and family members; wide, full-length plexiglass mirrors; and hammocks for rocking infants all offer emotional support. (Hammocks work better than rocking chairs because they allow the caregiver to rock more than one infant at a time if necessary. Rocking chairs can seriously hurt an infant who crawls behind one in motion; they also take up floor space,

while hammocks can be taken off their hooks and stored when not in use.)

Windows—especially those that open and look out to trees, grass, and passersby—contribute to a relaxed setting. Because older infants and toddlers love to watch others, child-level windows that look into another classroom can function as an additional learning center.

Privacy

Being alone provides time essential for reflection and growth. Although most adults recognize the need for privacy, we often expect infants and toddlers to function well in group care situations for upwards of ten hours a day, five days a week. Private spaces in the group care environment support the development of the young child's self-concept and personal identity. They assist all ages in understanding the "I" in relation to the "thou."

A private space could be a tunnel, a carpeted built-in cabinet with the doors removed, a cozy loft space, or a few risers enclosing a small corner of the room. Instead of experiencing the stress of being in a large group all day, the infant can withdraw to a private space to rest, observe, and recharge emotionally. With access to a private space, two toddlers who are just beginning to develop a relationship can go off together. Opportunities for privacy not only support the infants' developing sense of self; they also reduce aggression among children.

The people in the environment

While a developmentally designed environment adds significantly to the quality of group care for infants and toddlers, other components of care are equally critical. While considerable attention has been paid to adult/child ratios, caregiver training and parent involvement, group size has still not been recognized uniformly as a key variable in quality care. A decade ago the National Day Care Study (Ruopp, 1979) found that too many children and adults grouped in one space affected relationships adversely. When more than seven infants or eleven two-year-olds were cared for in a group—even with one adult for three infants and one adult for four two-year-olds—observers saw more crying, hostility, and apathy and less cooperation, reflection and elaborate play than in smaller groups. In large groups, the infant experiences sensory overload and has a harder time forming a close relationship with a specific caregiver; forming a group identity is difficult.

Conclusion

A developmentally designed environment offers infants and toddlers opportunities to explore, make choices, and master their world. It offers caregivers a chance to be observers, facilitators and supporters of all aspects of development in the early years. A well-designed child care environment not only reassures families but invites them. When an environment is designed to be functional, attractive and developmentally supportive, everyone feels well cared for.

References

Ruopp, R., Travers, J., Glantz, F., and Coelen, C. 1979. Children at the Center: Final Report of the National Day Care Study. Cambridge, MA: Abt Associates.

13

Shared Reading in Daycare: Successes and Challenges

by Grover J. Whitehurst & Janet E. Fischel

In her wonderful book, Beginning to Read (MIT Press, 1990, pg. 85), Marilyn Adams estimates that a typical middle class child enters first grade with 1,000 to 1,700 hours of one-on-one picture book reading, while the corresponding child from a low-income family averages 25 such hours. "Is there any chance," she asks, "that [the] first grade teacher can make up for that difference in 360 hours of one-on-twenty instruction?" The obvious answer is no.

Title XX programs, work-fare initiatives, and various job training programs have resulted in large numbers of children from low-income families receiving publicly subsidized daycare. At the Stony Brook Reading and Language Project, we have been exploring daycare as an environment that might compensate for some of the impoverishment in experience with books that is the lot of many children from low-income families.

We have just completed a study with 70 three-year-olds from low-income families in five daycare centers in Suffolk County, NY. Children in each classroom in each center were assigned randomly to one of three conditions. Two treatment conditions involved an intervention called *Dialogic Reading* that we developed and have shown to be effective in other settings. In our study, children in a school+home condition were read to at home by their parents and at school in small groups by their teachers using dialogic techniques. In a school-only treatment condition, children were read to in small groups by their teachers, but parents were not involved. Finally, in a control condition, children engaged in small group toy play under the guidance of their teacher. The intervention lasted six weeks. Children were pretested and post-tested on a variety of assessments of language development.

The good news is that the intervention works in this setting. Children in the school+home condition were significantly ahead of children in the control condition on standardized tests of both receptive and expressive language; the differences were about 2/3 of a standard deviation, which corresponds to about five months of language age in this age range. Children in the school-only condition fell in between children in the control and school+home conditions. We also looked at more specific measures of vocabulary growth and found that children in the school+home group had learned large numbers of new words that were specific to the books they had shared with their parents and teachers. We are excited by these results because the effects are reasonably large for such a brief intervention, and because we had not been sure that parents of low-income children and daycare teachers would be successful dialogic readers.

At the same time, we have learned how much more we need to learn to turn daycare centers into wellheads of literacy for young children. Of the five daycare centers with which we worked, one did not implement the reading package successfully in the first

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We are leaning towards volunteers to provide one-on-one or small group shared book reading for children in daycare.

place (reading only about once per week rather than once per day as encouraged), and another dropped the program as soon as we had post-tested the children. Only two of the five centers have continued the reading program with enthusiasm, even though each center was informed of the positive results. A principal issue is organizational. Dialogic reading is interactional reading. It requires the child to talk and the teacher to listen and respond actively. These requirements mean that dialogic reading cannot work if a teacher tries to share a book with the whole class simultaneously. This large group reading was without exception the form of literacy experience that was employed in the daycare centers prior to our program. In contrast, we insisted on no more than a one-to-four ratio for shared reading. On paper, each center had enough staff to accomplish this arrangement, with the typical classroom/group consisting of about 14 children, a teacher, and a teacher's aide. It meant that one adult would need to care for the majority of the children while the other adult engaged in shared reading with a smaller group. Three such sessions of about 10 minutes each during the day would have allowed each child in each classroom a daily dose of small group shared reading, and would have required only about 30 minutes of reorganized time out of the daycare day. However, daycare centers are not by tradition organized so that children are divided among adults in a way that approximates the staff to child ratio. Rather, one adult often takes charge of a large group, while the other adult prepares materials for later use, handles problem children, or takes a well deserved break. Or both adults provide traffic control functions and handle problems as all children are engaged in play activities. Reading to children in small groups requires a different organization, and it is seen by teachers as more effortful than their typical practice. Another organizational issue has to do with training and encouraging parents to share books with their children at home. Several of our daycare centers never have parent meetings, and they are not routine in any. We have shown that parent involvement is a critical component of success, but someone has to care enough to engage parents in the process.

What are the solutions to these problems? Over the long term, one might hope for a gradual increase in the standards and practices of daycare centers so that they become more educationally relevant and so that the development of linguistic and cognitive skills in children and the involvement of parents as partners in educational goals are seen as critical components of their mission. However, that may be a very long term goal. As witness, the daycare centers that cooperated in our program are much better than the national average. For instance all are nonprofit centers whose directors hold college degrees and have a strong sense of mission. Many of the teachers are also college graduates and the facilities are appropriate and well maintained. Staff turnover is relatively low. Problems in instituting a shared reading program in these settings would be dwarfed by those that would likely be encountered in run-of-the-mill proprietary centers with low wage, high turnover staff in states with minimal regulation of daycare.

We are leaning towards using volunteers to provide one-on-one or small group shared book reading for children in daycare. The success of groups such as Literacy Volunteers of America in working with problems of adult illiteracy suggests that there is a large pool of people who will volunteer their time to advance the cause of literacy. It would take only five adults, each willing to volunteer 30 minutes a week, to staff a small group shared reading program for a typical daycare classroom. Some of these adults could probably be found among the family members of children in daycare. Retirees are another potentially large group of volunteers.

We do not underestimate the problems involved in instituting wide spread volunteer programs for shared book reading in daycare

centers, or in incorporating some other mechanism for shared reading into preschool programs. The task is formidable. In justifying the effort, I turn again to Marilyn Adams, who says, "We hug [children], we give them ... good things to eat; we try to teach them to be clean and polite, good natured, thoughtful, and fair ... We must do as much with reading. In our society, their lives depend on it" (1990, p. 91).

14

Managing Growth at Child Care Solutions

by Ruth Anne Foote

Child Care Resource and Referral (CCR&R) Services see themselves as a vital part of the country's child care system. Their rapid growth during the last decade has resulted in large part from the urgent demand for infant child care. When Child Care Solutions began to provide resource and referral services for 11 metropolitan Atlanta counties in 1983, 42.5 percent of the parents who called that year were seeking care for children under 12 months. In ensuing years, the percentage has remained fairly constant, ranging only from 36 to 42 percent. The parents who have called upon Child Care Solutions are often first-time users of child care. Their families have never turned to sources outside the family for infant care, and their employers' personnel policies have assumed that children were cared for by a non-working spouse. They have found little in their experience or their support structures to help them locate and select caregivers for their babies.

Child Care Resource and Referral Services can provide much needed support, not only to parents, but to all constituents of a child care system, including providers, employers and communities. In order to cope successfully with increasing demand, however, a CCR&R must manage its own growth carefully. This article describes several major principles for managing growth that have helped us at Child Care Solutions through the exhilarating process of coping with current demands, and gathering resources to meet new demands.

The growth of Solutions

Child Care Solutions began in 1983, a project of Save the Children's Child Care Support Center. For the first five years of its existence, Solutions was the only CCR&R offering referral to the general public in Georgia. Solutions began with a $5,000 grant from the Metropolitan Atlanta Community Foundation, a $3,000 grant from the Gannett Foundation, and three part-time staff members working a total of 33 hours per week. Fortunately, Solutions' parent agency, Save the Children, was willing to absorb significant administrative costs, and its own staff members were willing to double up on responsibilities in order to meet a pressing community need. The referral service listed 630 family day care providers in seven counties in its data base and offered referral to 2600 parents in its first year.

By 1990, Child Care Solutions employed 16 full time equivalent staff members and listed 1094 family day care providers, 643 centers, 257 school-age programs, and 96 half-day preschools in eleven counties in its data base. It offers referral to 8,000 parents each year. (All referrals are to providers registered with the Department of Human Resources, but referrals are not recommendations.)

Our range of services has widened as well. In addition to counseling parents, Solutions offers:

- a provider warm line, which offers technical assistance and information on registration and training to family day care providers;
- two family child care resource rooms in suburban counties;
- a consultant who assists churches and not-for-profit organizations in starting child

care centers and programs for school-age children;

- a trainer who works with both centers and family day care providers; and
- an emergency child care specialist who assists families in crisis in resolving child care problems.

Solutions manages contracts offering "enhanced referral" (vacancies are confirmed before parents are called back) and other employee assistance to 100 companies. Sister programs at Save the Children/Child Care Support Center offer payment for child care through vouchers, special assistance, and advocacy for quality child care in three low-income communities; provide advocacy and technical assistance on school-age child care issues; and offer special assistance and support to refugee families and family child care providers. Staff of Child Care Solutions have assisted in the organization and development of three new CCR&Rs in other parts of Georgia and are helping to develop two more services during 1991. We have joined with these five groups to organize a Child Care Resource and Referral network for Georgia.

How does a project manage growth like that? Our seven years of experience have taught us some principles that seem worth sharing.

1. If you expect rapid growth in a project, start with careful planning and get a good foundation before you begin to grow.

Save the Children/Child Care Support center staff spent several months in research and consultation with experts around the country before opening the referral service. We collected an extensive library of CCR&R materials from other agencies. We stated basic goals for the project, thought through procedures, and put policies in writing before collecting the database and beginning referrals. We developed plans for collecting and analyzing data.

What is Child Care Resource and Referral?

Child Care Resource and Referral Services are a vital part of the country's child care system. They serve all the system's constituents.

- CCR&R offers referral, consumer education, problem solving, and information on child care to parents, usually through telephone consultations.
- CCR&R offers training, technical assistance and consultation to child care providers, much of it directed toward helping family day care providers and other child care programs get started and meet licensing or other standards.
- CCR&Rs work with employers to help them understand their employees' work and family conflicts and offer programs to relieve work/family stresses.
- CCR&Rs work with communities to help them plan for children's needs for care while parents work. The focus is on the collection of data on child care demand and supply, and advocacy to help communities develop affordable, accessible, quality child care.

Other CCR&Rs around the country were (and still are) generous with advice about what worked and what didn't. Solutions staff took the advice seriously and developed a service that reflected the best thinking of those experts. As a result, while we have done a great deal to fine-tune those early policies and procedures and to expand our scope, little has had to be undone and done over at the referral service itself.

This is a difficult principle to put into place retroactively. When an agency finds itself under great stress from high demand for service and only then recognizes that it lacks basic structures to deal with such demand, it is hard to stop and redesign structures. Especially if its manager is service oriented and impatient with planning processes, an organization can become less and less effective. Sometimes an outside consultant can assist if work on basic structures must be undertaken in an ongoing operation. However, the people who are carrying out the day-to-day business of an agency are the people who know what needs to be done.

They need to be the decision makers in this kind of process; the consultant is the facilitator.

Agreed-upon goals, well-thought-out procedures, and clearly stated, fully understood policies become more and more critical as demands for service increase. For example, we formulated a complaint policy, with procedures to follow in dealing with both parents and providers, before we opened our first referral line.

2. Manage demand to the extent that you can.

Child Care Solutions began small, with a plan to expand. During the first year of operation, Solutions referred to family day care providers only, adding other forms of care in subsequent years. Promotion of the service to users also began small; we notified other social service agencies of the service and placed classified ads in neighborhood newspapers. Later we sought greater exposure through advertising in the Yellow Pages, television and newspaper public service announcements, and press releases. These efforts never were a primary activity, since demand for referrals rapidly challenged our ability to respond, and has remained high.

Eighteen months after the project began, staff found themselves overwhelmed by parent demand. Parents experienced long delays in getting referrals, and counselors were spending valuable telephone time explaining to parents why they couldn't work any faster. This was an experience we were going to repeat in some form on other occasions.

A timely visit from Ethel McConagy and Fran Rogers of Work/Family Directions helped us to manage the crisis. They suggested that we turn our telephones off earlier in the day; we would thus limit callers to the number we could serve. We did this, using the moments of relief to take a look at our referral procedures and redesign them to be faster and more effective. We discovered that the numbers of parents we served did not go down, but staff stress was greatly reduced.

3. Growth in staff size is itself a crisis. It needs to be planned for and managed well.

One of Solutions' first service problems concerned how to maintain an equal opportunity referral service when requests from parents and providers conflicted with our policy. To deal with this issue, all members of the staff sat down together and hammered out a policy statement and procedures. The whole staff knew the policy and followed the procedures. Helping new staff (who were not at that meeting and do not even work directly with anyone who was there) to understand and implement the same policy is a task that requires more time and skill than developing the procedure in the first place.

As staff grows, good trainers of new staff and good supporting materials for the training are critical to maintaining a project's original quality and level of commitment. Project managers are often reluctant to let go of the task of orienting and training new employees, even though other demands on managers' time mean that orientation and training are slighted.

A gradual process of turning over responsibility for training to another staff member—eventually to more than one other person—often works. The manager may begin the orientation of new employees herself and then turn over parts of the training to experienced staff members. At the same time, she may designate a staff member to pull together training materials and procedures. Eventually, one of those staff members will have demonstrated the interest and ability to take full responsibility for training new employees. If she or he is given plenty of time to work on the project, careful attention, and increasing responsibility, she or he will develop in the job. Eventually even the most reluctant of managers will feel comfortable delegating responsibility for training of new staff.

Project managers can follow the same pattern in releasing and delegating other management functions which they at first feel uniquely qualified to undertake.

4. Think carefully about how you introduce change in a growing program.

The old card files and office set-ups that worked for a few part-time staffers become dysfunctional as a program grows. Managers begin to fantasize about computers and expanded space. New systems, however, may not solve existing problems as quickly as staff members would hope, and they frequently create new problems along the way.

Rearranging space: Urgent demands on space are common to growing, underfunded programs. Most of us who thrive on developing new programs assume that the ability to function in crowded work spaces is a sign of competence and strength of character. There comes a point, however, when congested work space impairs program function. Rearranging or expansion must begin. Child Care Solutions survived several rearrangements of space, with varying approaches and results.

Once, a few staff members remained behind in the evening and rearranged the office space without consulting other staffers. They achieved an efficient use of space, a quickly completed project, and a less than positive response from their unconsulted colleagues. On the other hand, we realized the rearrangement of space begun with a brainstorming session and working toward consensus would require more time and patience with group process than most of us were willing to invest. Staff reacted well to a process that involved key staff members developing alternative plans, inviting reaction and advice from users of the space, adapting the plan in light of the advice, and describing the rearrangement before it occurred.

Similar consultations with staff improve the quality and acceptability of changes in record keeping systems, work schedules, and other program structures.

Computers: When demands increase more rapidly than resources, most of us hope that computers will help us cope. But our CCR&R counselors had serious concerns about the possibility that computers might reduce the personal quality of their work. In order to make best use of what computers offer and keep the most personal quality of child care consultation and referral, adaptation is required of both counselors and computer systems. Solutions used computers gradually, beginning with storing data in one small personal computer and moving to a networked system with counselors doing intake and referral searches on line.

To make the transition work, we needed the help of computer experts who were willing to take the counselors seriously, counselors who were willing to change, and lots of time. Glitches and failures were a part of our transition. Counselors had to "check" computer systems by their old manual systems—some more times than others—before they really trusted the computer. We spent more time than we had expected, and confronted and solved more problems than we had imagined, before new computer systems became as effective as we had hoped. We retain a manual referral system to use for back-up when the computer system is down.

5. Flexible staffing patterns, and flexible staff, help agencies cope with growth.

From the beginning, Child Care Solutions has relied on counselors who work on the referral phones part-time. Some counselors are part-time workers; others are full-time employees who have other tasks in the agency and spend some time each week on the referral phones. The arrangement reduces burnout, since telephone referral is a demanding and repetitive task. It had enabled us to employ some excellent staff who wished to work part-time, including mothers of young children, graduate students, and

retired professionals. Part-time telephone counseling also has allowed employees to carry out a variety of tasks and prove themselves adept at new skills before new positions opened in the growing project, giving us a good opportunity to train and promote from within. Maintaining and supervising a part-time staff increases demands on the supervisor, however; he or she becomes the primary communicator with an in-and-out staff.

The combination of program growth, the use of part-time staff, and promoting from within results in a staff which is often in transition. Flexibility is necessary in staff members who work in a rapidly growing program. For people who need a lot of control over their jobs, rapid growth may be more frustrating than invigorating. New programs and programs that expect rapid expansion need to look for workers who are flexible, creative, and face change confidently.

6. An established agency can help significantly to develop and stabilize a rapidly growing new program.

Much of Child Care Solutions' success and rapid growth can be credited to the fact that we are a part of a larger agency, Save the Children/Child Care Support Center, which has used its resources to develop and stabilize our program. Being part of a larger agency, whose purpose is to improve the lives of poor children by improving child care, has helped to develop and articulate the goals of Child Care Solutions. Child care resource and referral agencies' constituencies and funders are so diverse that direction and focus can be difficult to maintain. While we at Child Care Solutions continue to be challenged by growing demand and are eager to expand our role, our place within Save the Children clarifies our purpose—to help make quality child care available for Atlanta's working families, and especially for the poorest of those families.

Fulfilling that task and finding the resources to do so will continue to be a demanding venture.

Research on infant/toddler child care

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More Pride, Less Delinquency: Findings from the Ten-Year Follow-Up Study of the Syracuse University Family Development Research Program

by J. Ronald Lally, Peter L. Mangione, Alice S. Honig and Donna S. Wittmer

The findings were dramatic, and captured the attention of *The Washington Post*, *The London Times*, and *The Los Angeles Times*. Ten years after their participation in the Syracuse University Family Development Research Program, children had a 6% rate of juvenile delinquency compared to a 22% rate for children in a control group. Not only was the control-group delinquency rate almost four times greater, but the offenses were much more severe. Of the four program-group children with probation records, three were charged with simple unruliness and the fourth with one-time juvenile delinquency. In contrast, of the 12 control-group children with criminal records, five were chronic offenders; control children committed acts of burglary, robbery, physical assault, and sexual assault. In addition, the cost to the court and probation department for handling the cases was estimated at $12,000 for the program group and $107,000 for the control group.

Our findings—associating high quality early education and family support with reduced delinquent behavior in adolescence—correspond to those of the longitudinal study of the Perry Preschool Project (Berrueta-Clement, Schweinhart, Barnett, Epstein and Weikart, 1984). Significant findings in other areas emerged from our follow-up study as well.

- Girls in the program group, but not boys, were performing significantly better in school than their counterparts in the control group. Interestingly, these positive findings only began to appear during early adolescence; information on the elementary school years indicated no differences between the program and control group. By the 7th and 8th grades, three-fourths of the program-group girls had C averages or better; none was failing and none had more than 20 school absences during the previous year. In contrast, more than half the control group girls had averages below C; 16% were failing; and 31% had more than 20 absences. Teachers rated girls from the program group as having more positive attitudes toward themselves and other people.

- Compared to control-group parents, parents who had been in the program reported feeling proud about the positive social attitudes and behaviors of their children and the degree of unity in their family. They were also more likely to advise

young people to learn something about themselves and accomplish all they could, while control parents were more inclined to counsel young people to concentrate just on "getting by."

- Compared to control-group children, those in the program group felt more positively about themselves in early adolescence and were more likely to expect education to be a continuing part of their lives. Fifty-three percent of the program group but only 28% of the controls anticipated that they would be in school at age 17 or 18.

Statistically significant findings such as these are precious to practitioners, program developers, researchers, policymakers, and advocates concerned with the well-being and development of children and families. They bolster our clinical knowledge of the positive effects of high quality early childhood experience. Findings concerning the differences between program and control children that seem to emerge only over the long term, in important domains such as school performance and delinquency, are particularly important to bring to the attention of decisionmakers. In addition to being able to "chalk one up" on the side of the scorecard that says, "early intervention works," it is also important to describe in some detail what *kind* of early intervention seems to be effective, and for whom. Planners and implementers of demonstration programs must make clear whom they served, what they hoped to accomplish, how they proceeded, and the conceptual underpinnings of their interventions if others are to be able to understand and replicate their work. This article first gives a feeling for the philosophy and way of working of the Family Development Research Program, and second delineates the follow-up effort, procedural issues in this kind of research, and the meaning of its major findings.

The Family Development Research Program: Target audience and conceptual framework

Like other intervention programs begun in the 1960s and '70s, the Family Development Research Program (FDRP) attempted to break the well-documented link between low-education, low-income households and children's later educational difficulties. Unlike other programs which focused on preschoolers *or* on infants, *or* on parents, the FDRP provided a full complement of education, nutritional, health and safety, and human services resources to families beginning prenatally until children reached elementary school age (Honig, 1977; Honig and Lally, 1982; Lally and Honig, 1977a). In 1969, 1970, and 1971 FDRP recruited 108 families with incomes of less than $5000 per year (in 1970 dollars) into the program in the last trimester of pregnancy. Mothers had less than a high school education, and a history of either no paid work or semi-skilled work. Their mean age was 18 years; more than 85% were single parent heads of households. Despite energetic attempts to maintain racial balance in the program, the majority of families served were black.

Our intervention was designed to influence the permanent environment of the child, the family and the home.

Our intervention was designed to influence the permanent environment of the child, the family and the home. We saw parents as the primary teachers and sustaining caregivers in a young child's life, and hoped to support parent strategies which would enhance the development of the child long after intervention ceased. Consequently, we viewed parent contact as the primary intervention and child care as supplementary; this strategy differed from that of child-oriented programs of the time, which saw enriched child care as the core of the program and parent contact as "outreach." In actual operation of the program, however, both parent contact and child care became crucially important and integrated aspects of the comprehensive, long-term intervention. We assumed that a guarantee of high quality child care for 50 weeks a year for the first five years of their

children's lives would greatly assist families in meeting the life challenges they faced, as well as positively influence the perceptions, emotions, and intellect of the children served.

Five theoretical rationales shaped the goals and objectives of the intervention program.

- Piagetian equilibration theory, which stresses judicious provision of toys, materials, and human interactions in sensitive relationship to the developing abilities and understandings of the child, helped to shape the infant curriculum both in the home and center. Piaget's attention to the crucial importance of active child participation in the construction of knowledge was also emphasized.

- Language developmental theories suggested that adult modeling and expansion of child language, contingent responsiveness to early infant coos and babbles, interactive turn-taking talk, and frequent book reading would increase child language repertoire (Bernstein, 1964).

- Erikson's theory of each child developmental stage as, optimally, the positive outcome of a series of nuclear conflicts or struggles between opposing emotional adjustments and attunements, focused program concern on the development of basic trust, sturdy autonomy, and learning initiatives in the children served (Erikson, 1950).

- Saul Alinsky's (1971) theory of community organization shaped the way in which FDRP personnel perceived their role in the community served and the tone with which parent contacts were maintained. Alinsky had theorized that "To give people help while denying them a significant part in the action contributes nothing to the development of the individual. In the deepest sense it is not giving but taking—taking their identity" (p. 123).

- From John Dewey and the British Infant School movement, the FDRP project drew the concepts of the importance of freedom of choice for children, encouragement of creativity, and design of an environment that supports exploration in a spatial rather than exclusively time-bounded organization of programmatic offerings.

Child care staff at the Syracuse University Children's Center functioned under a more specific set of agreed-upon assumptions. They believed that the program children were capable of:

1) learning something about anything in which they showed interest;

2) learning to understand that their actions and choices had an impact on others;

3) learning that cooperation and concern for the rights of others would ultimately allow them to express their own creativity, excitement, curiosity, and individuality more fully;

4) learning that wonder and exploration were encouraged by adults; and

5) imitating the actions of staff toward children and other adults.

Additionally, these children were treated as special creations, each with particular skills and specialties that would be appreciated by and useful to the larger society. These special powers were to be protected and allowed to rise to ascendance by the adults who spent the daytime hours with them. In summary, the context that was fostered set a daily tone of freedom of choice and awareness of responsibility; an expectation of success in each child; confidence in the fairness and consistency of the environment; an emphasis on creativity, excitement, and exploration in learning; expectation of internal rather than external motivation; and a safe, cheerful place to spend each day.

Program components

Parent involvement: The major thrust of FDRP was to maximize family functioning by supporting a rich quality of family interaction and increasing family cohesiveness. A cadre of paraprofessional home visitors called Child Development Trainers (CDTs) was recruited and trained intensively to encour-

age strong, nurturing mother-child relationships that involved giving affectionate bodily contact, respecting children's needs, and responding positively to young children's efforts to learn.

During weekly home visits, CDTs taught families Piagetian sensorimotor games during daily routines. They also helped mothers to learn ways to modify games and activities in order to match the unique interests and characteristics of the individual child. CDTs offered positive support and encouragement to mothers as they interacted with their children and also responded positively and actively to the parent's need to fulfill her aspirations for herself. Many mothers came to rely on the CDT as an advisor and confidante on personal relations, finances, career changes, and education. The CDT served as a liaison between the family and community support services, including the child care component of FDRP; in addition, she helped families to learn to find and use neighborhood resources on their own, for example, giving families specific practice in learning how to make and maintain contact with school personnel as children reached school age.

All caregivers were encouraged to use creativity in embedding learning activities in daily care routines and informal encounters.

The Parent Organization. As FDRP progressed, parents developed both formal and informal associations. One group of families, specifically concerned about the education of their children after FDRP, asked for training in classroom observation and for information about parents' rights in relation to the schools. They observed Syracuse kindergarten and first grade classrooms and made their findings available to program parents so that they could be advocates for their children. Informally, parents joined together for cooperative food purchasing; two single mothers in the program moved in together to share resources.

The Children's Center. A pioneer child care and educational facility for infants, toddlers, and preschoolers, the Children's Center was founded in 1964 by Bettye Caldwell. When I. Ronald Lally became project director of FDRP in 1969, the Children's Center already had a well-trained staff and a strong local and national reputation. Lally added the FDRP home visitation component and an open-education model for children from 18 to 60 months of age. Alice Honig remained program director of the Center, where she supervised staff training and assessment of the multiple components of the FDRP.

The Children's Center, lodged in a huge church basement, included three main groupings that were designed to accommodate developmental stages of the children served.

Infants 6 to 15 months of age were cared for in an "Infant-Fold" five days a week for a half day each day. Each caregiver was assigned to four infants. Caregivers worked in pairs, with group size limited to eight infants. The caregiver assigned to an infant was expected to form the principal relationship with the child. Activities were tailored to the individual level of skill of each child. All caregivers were encouraged to use creativity in finding ways to embed Piagetian sensorimotor games, fine and gross motor activities, sensory stimulation and activities, and language and book experiences in daily activities, daily care routines and informal encounters, as well as in more formal learning experiences.

Babies from 15 to 18 months were in a special transition group with full-day care five days a week. Self-feeding was encouraged, and larger play spaces with sliding cabinets encouraged toddler autonomy and freer choice of materials. Comforting and emotional support from the caregivers remained freely available to these older babies.

Children from 18 to 60 months were together daily in a family style environment designed by Margaret Lay (Lay and Dopyera, 1977) and similar to the British Infant School in philosophy and structure. Children had freedom of choice and access to four major areas: large muscle, small muscle, sense perceptions, and creative expression/snack. Additionally, the children had a large variety of wheeled toys and equipment in the big